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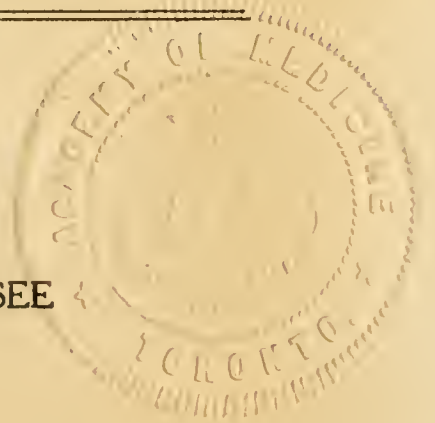
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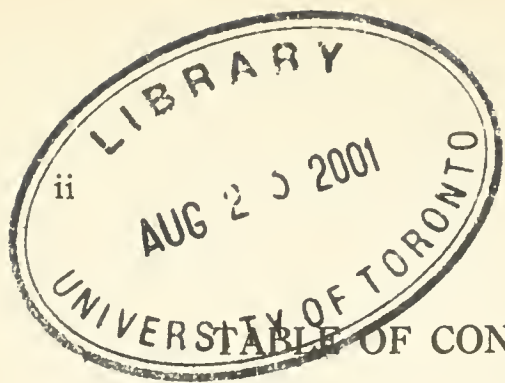
MEDICINE and SURGERY

C. S. BRIGGS, A.M., M.D.
EDITOR and PROPRIETOR

Volume 106—January-December, 1912

NASHVILLE, TENNESSEE
1912





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NASHVILLE JOURNAL — OF — MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

VOL. CVI.

JANUARY, 1912.

NO. I.

Original Communications

BRAIN SOFTENING.*

BY M. CAMPBELL, M.D., KNOXVILLE, TENN.

It is not my purpose to treat exhaustively the subject of brain softening, as it would far exceed the limits of an article proper to be read on this occasion, but to describe briefly the ordinary development of the disease, and give an account of a case that recently came to me for treatment, and which illustrated one of its rarer forms. As most cases of brain softening are caused by occlusion of its blood vessels, I shall briefly call your attention to the cerebral circulation.

The brain receives its large supply of blood from the vertebral and internal carotid arteries, which form, by their divisions, the cerebral and cerebellar arteries. The subdivisions of these last-named vessels, besides supplying the ventricles, ramify in the pia mater. This membrane is thrown over the brain like a net, dipping down into the sulci of the convolutions, and sending blood vessels to the white matter of the interior, both from below upwards and from above downward.

The gray matter, both of the cortex and basal ganglia, because of its greater functional activity, is more abundantly supplied with blood than the white. Softening of nerve tissues consists in, and is due to the breaking up of the elements, the resulting particles become saturated with serum, so that a soft pulp

* Read before the Knox County Medical Society.

replaces the original firm tissue. This is the characteristic effect of inflammation, most often seen in the focal inflammation following hemorrhage of the brain. Formerly all softening was thought to be the result of inflammation, but it is now known that in the majority of cases, it is caused by the occlusion of an artery, vein or sinus, cutting off the blood supply from the part beyond the place of obstruction. These obstructions are caused either by embolism or thrombus. An embolism may be described as a plug in an artery of the brain, which has come from a distance, usually from the heart, and is an evidence of disease elsewhere than in the brain, while a thrombus is the effect of local disease of an artery in the brain, by which its caliber is narrowed or its intima roughened, so as to cause coagulation of the blood. The chief causes of these changes in the inner coat of an artery that cause thrombus are atheroma and syphilis. The source of a plug in embolism may be anywhere between the lungs and the brain; detached material from a pulmonary abscess may come through the pulmonary veins to the left side of the heart, and from there find its way to the brain. Or it may be the result of an endocarditis, ulcerative or rheumatic. In these cases, Gowers says that there are frequently vegetations on the valves which may become detached, and thus washed into the blood current. Softening is divided into three classes, red, yellow and white. Red softening is found generally in parts where the blood vessels are most numerous, in the cortex and ganglia. Yellow softening comes from red softening by degenerative changes. White softening does not differ from the color of white matter of the brain where it is found. Its consistence is variable, sometimes diffuent, but more frequently like firm ice cream. The most frequent seats of softening are the cortex, corpus striatum and optic thalamus, but any portion of the brain may suffer. Changes occur very rapidly after the occlusion of an artery. In one of my autopsies forty-eight hours after the attack, a large area of softening was found, the result of an embolus. The symptoms were those of an apoplectic stroke, with hemiplegia. The hemiplegia was with difficulty made out, owing to the prostration and unconsciousness of the patient.

When we consider the causes of the occlusion of the cerebral arteries, and remember how large a proportion of the human race suffers from endocarditis, syphilis and atheroma, the statement that softening is one of the most common brain diseases is not surprising. Neurologists generally hold that it is more common even than hemorrhage. The symptoms of cerebral softening in the majority of cases, resemble strongly those of hemorrhage, and diagnosis of softening is made rather from general considerations, than the immediate symptoms at the time of the attack. Hemorrhage is improbable in a patient under forty years of age. If, in addition, there is a history of heart trouble or syphilis, the symptoms point strongly to softening, and the diagnosis may be made with reasonable certainty; the greatest difficulty is encountered in patients past middle life, for the greater probability of hemorrhage at that age is accompanied by atheroma and arteriosclerosis, which are causes of softening; given a case with full bounding pulse and flushed face, hemorrhage is indicated rather than softening, notwithstanding evidences of arterial degeneration; deep coma is also more characteristic of hemorrhage. Unfortunately, profuse hemorrhage causes pallor, and feeble pulse, and in some cases of apoplexy in the aged, the most expert diagnosticians can only be sure of the lesion after an autopsy; notwithstanding the difficulties of diagnosis in some cases of necrotic softening, no pains should be spared to arrive at the true nature of the lesion, as the initial treatment of softening differs radically from that of hemorrhage. In hemorrhage the indication is to lower the blood pressure, to quiet the action of the heart, and thus favor coagulation, while in softening coagulation is the foe to be dreaded, and is best combatted by sustaining the action of the heart with digitalis and strophanthus. The above briefly described forms of brain softening is applicable to the ordinary development of the disease, and does not include certain rarer cases that may have a different symptomatology, one of which recently fell under my notice.

There was brought (on July 31, 1910) to the Eastern Hospital for the Insane, near Knoxville, Tennessee, Mr. M. L., aged twenty-nine. He had a history of syphilitic infection six years

before his admission, and had gone to Hot Springs, Arkansas, for treatment. He was in charge of my colleague, Dr. S. R. Miller, during the fall of 1909, when nervous symptoms developed. He complained of severe pain at the base of the skull, and the head was abnormally sensitive to percussion. He also suffered with deep-seated pain apparently in the center of the cerebrum. His suffering was worse at night, when he would continually walk the floor. Later, mental symptoms developed, and he was sent to the East Tennessee Hospital for the Insane, where, as above stated, the patient arrived on the 31st of July, 1910. He had been treated by Dr. Miller with both mercury and iodide of potassium, and had improved. The result of the treatment was to relieve him from the severe pains in the head. Examination at the time of his reception showed marked dementia, and while there was no paralysis, there was a spastic condition of the muscles like that found in advanced cases of paralysis agitans, and he had the propulsive gait characteristic of that disease. On August 6th he gradually lost the use of himself, and became unconscious, but there was no complete paralysis, but rather a more pronounced spastic condition. His temperature ranged from 103 deg. to 105 deg. He lingered in this condition until the 10th of August, when he died. Autopsy twenty-four hours after death. The dura was strongly adherent to the base of the skull, with other evidences of former pachy-meningitis. A minute examination could not be made of the blood vessels, as the pia as well as the brain substance was torn when they were taken from the calvarium. While making thin horizontal sections of the right hemisphere at the distance of one-half an inch from the superior surface of the middle lobe, the knife passed into several lacunae, entirely empty, from the size of an average pin to large broom straws. They penetrated an inch or more down toward the basai ganglia. In the centrum ovale, halfway between the vertex and the corpus striatum, an area of softening was found, one inch deep, and into which the middle finger could be thrust. Other portions of the brain substance to the naked eye were apparently normal. Microscopic sections were not made. The early nervous symptoms in this case; severe nocturnal headache, etc., were evi-

dently due to the pachy-meningitis of syphilitic origin. The lacunae, an area of softening, were caused by syphilitic occlusion of the long arteries that penetrate downwards and inwards from the lateral and superior surfaces of the cortex for the nourishment of the white substance of the brain. These arteries do not anastomose with any others, and their occlusion necessarily results in necrosis of the parts that they supply with blood. The history of this case teaches that the physician should be cautious in giving a favorable prognosis in nervous disease due to syphilis, for while it is true that many severe paralyses caused by syphilitic inflammation and gummata respond brilliantly to anti-syphilitic treatment, the probability of incurable necrosis should not be lost sight of.

A DEVOTED PATIENT.

BY DR. E. S. M'KEE, M.D., CINCINNATI, OHIO.

In 1883 the reporter of this was a poor doctor. Poor in purse, poor in knowledge and poor in experience and poor doctor to the Thirteenth Ward, that part of our trans-Rhenish possessions which has Findlay Market for its "court of honor." The Thirteenth Ward and Findlay Market are bisected by a street called Pleasant. Why so called I do not know. I was called to that portion of Pleasant Street south of Findlay Market to see a woman whom we will call Anastasia Lemkuhl. That was not her name, but it will serve to indicate her descent and ascent. There was nothing particular about the illness or the treatment that I can remember, but that was the start of one of the most remarkable cases of devotion of a patient to her physician that it has ever been my lot to meet. I held the position of poor doctor to the lucky Thirteenth for three years, but my successor could never touch Anastasia. She moved frequently, Race, Elder, Elm, Pleasant Dunlap, Stark, Logan, Bank, McMicken and Mohawk. She often changed her residence, but never changed her doctor. It is the women who make or mar the young doctor. She brought me her children, grandchildren, grandparents, broth-

ers, sisters, uncles, aunts, cousins, her -in-laws, friends and neighbors. She had four children, two boys and two girls. The father of these children I never saw. In my long acquaintance, over a quarter of a century, I heard only on rare instances a complaint from the children about their father, never one from their mother. I know not whether he be living or dead, and I have made little effort to find out. It reminds me of the little girl's talk to her kitty: "Kitty, I knows your brothers and I knows your sister, and, Kitty, I knows your mother; but, Kitty, I never did see your father." Rumor said—but it matters not what rumor said. She remained true to her church and clung to the cross. How well I remember the eldest child, a little, skinny girl of ten years, when she had the typhoid fever. Fearing contagion, everybody deserted her but her mother, who watched her day and night for four weeks, fearful that in her delirium she would jump out of that fourth floor window. Thanks to the faithfulness of the mother, the daughter recovered and is now a fine-looking matron. Frequent illnesses of herself and children were contracted and paid for during the years that followed. I well remember the winter of 1891-92. It was the year the grippe first came with us. Cold, snowy winter. She had the grippe and I had it. I did not know then how to treat the grippe, or I would have been at home in bed instead of going about in the snow trying to treat it. Neither of us did well. We were sick off and on all winter. It was this winter that I ran up a bill of fifty dollars against her. Former bills had all been small and promptly paid. This one staggered her, for she was always a poor woman. In fact, that bill stood for fourteen years. I had not sent her a statement for ten years, when one day, greatly to her joy, she paid it. Fifty dollars after fourteen years! Numerous small bills contracted in the meantime had been paid.

Meeting Anastasia one day on the street, I upbraided her for not having sent for me for several months past. "Well, you see," said she, "I bought a stand in market, and when the children gets constipated I just gives them oranges, and when they has diarrhea I gives them peanuts." Suggestive therapeutics! The many years that she stood in market she never failed at my numerous

visits to her house to try to fill my pockets with fruit and vegetables. Many a time would I take them, find a quiet spot and unload.

Teddy was the youngest child, and after a long and severe illness he died, greatly to the sorrow of his devoted mother. His death never for a moment shook his mother's faith in her family physician.

Henry was her oldest son. She loved Teddy, but she both loved and admired Henry. He was twenty-five and weighed 230 pounds. The idol of his mother's eye, more especially since the death of Teddy. A driver for a brewery, he never shirked his duty, but was always willing to haul a double load. I was called to see him and found a temperature of 104.6 and the patient out of his head. It was easy to diagnose typhoid fever, for he had had it for about two weeks and had kept about his work. His illness went from bad to worse, characterized by a very high temperature, insanity and meningeal symptoms. Things began to look serious. Consolation was suggested, and the priest came. He started Henry at saying the Lord's Prayer at 8 a. m., and it was impossible to stop him. He kept getting louder and louder, till you could hear him a square, and the voice would sing back in echo at you from the ceiling. I could occasionally change him from English to German, but say the Lord's Prayer he would time after time at the top of his voice. I called in Dr. Khoun, who lived in the immediate neighborhood, to help me. Four men from the brewery, who had been sent over to hold him, vanished one by one. Too much of a good thing gets on your nerves, and after a couple of hours of the Lord's Prayer, we administered chloroform. It took a good deal to affect him. His voice would slowly and stubbornly succumb to the anesthetic, when he would then go off into opisthotonos. Removal of the chloroform would be followed by a resumption of the Lord's Prayer, growing louder and louder, till in a few minutes it would be as loud as ever. This was repeated several times with the same effect. This condition went on till about half past two, when Henry died, saying the Lord's Prayer, he having been saying it constantly, unless profoundly under the influence of chloroform, since eight that

morning. There he lay, dead, his huge frame outstretched upon the bed, and at the foot, gazing down on her dead child. stood his mother, speechless and tearless in her great grief. At last her voice came to her, and this is what she said: "Dr. McKee treated my Teddy and he died; Dr. McKee treated my Henny and here he lays dead. When I am sick Dr. McKee will treat me, and if I die it will be all right." A most unparalleled instance of devotion of patient to her physician. Gentlemen, she kept her word. A few years later a tired artery in her weary brain, which had known little but sorrow, broke. I was called and treated her through a long and tedious illness, at the end of which she was laid to rest on our western hills between Teddy and Henny.

A few years ago I was called in to see little Carrie, fourth generation of this family. She was a descendant of Anastasia through her mother. Said mother had married neither too wisely nor too well. I had treated little Carrie all her life. She hardly thought there was another doctor in Cincinnati. She had tonsilitis, then rheumatism, then endocarditis. This lasted quite a while and I ran up a bill of \$18 at the meager sum of \$1 per visit.

One day I came in, and the mother, with tears in her eyes, told me that Charley, her husband, was an Eagle, and he had sent for the Eagle doctor, whom he could get for nothing, and he wouldn't have me any more, and that the Eagles' doctor had said Carrie had St. Vitus' dance. There was nothing left for me to do but to dance out, fired by the fourth generation. I have not, though I tried strenuously, been able to collect my bill. The Eagle's doctor is a member of this academy.

Herein lieth the tonnage of my text. A few years ago a member of this society read a paper on this floor on the subject of contract practice. The paper was a good one, created quite a discussion and led to the passage of resolutions by this society condemning the practice and making it incumbent on its members who were employed in that way to desist. The reporter of this was at that time physician to "La Societe Francaise de Secoures Mutueles de Cincinnati. His salary was one hundred dollars per year. I resigned my position, and with some regrets, for my real reason for doing the work was to keep from for-

getting what French I knew. The resignation was accepted with expressions of polite regret for which the French are so justly respected. They discontinued employing a physician, each member employing his own and paying him himself. I have failed to learn of another member resigning his contract practice. The member who read the paper on contract practice has left town, but I hope that the good work which he started with such energy will not be allowed to fall.

Selected Articles

THE TREATMENT OF ANTEPARTUM HEMORRHAGE.

Herman in the *British Medical Journal* of September 30, 1911, briefly sums up what he believes as follows:

Accidental hemorrhage, slight in amount, is not uncommon, and seldom dangerous.

Concealed accidental hemorrhage is a very dangerous thing and is rare.

Plugging the vagina is bad treatment. Practically it is illusory, for it only prevents the escape of blood for a little while. Theoretically it is unsound, for if it did prevent the escape of blood from the uterus it would only convert the case into one of concealed hemorrhage, which is the most dangerous form. The private practitioner must also recollect that it is extremely disagreeable to the patient; to speak of it as "horrible torture" is scarcely too strong.

The best treatment for the majority of cases is to rupture the membranes. This acts instantly, lessens the tension within the uterus, and stimulates the uterus to contract. Before doing this, care should be taken that the long axis of the child coincides with the long axis of the uterus, and, if possible, that the head presents.

If the patient has lost so much blood that it seems likely that the inevitable hemorrhage of the third stage of labor will be fatal, then the author thinks the best treatment will be amputation of the body of the uterus, after preliminary ligature of the vessels.

Placenta previa, as a cause of unavoidable hemorrhage before delivery, has been known to many generations of medical men and midwives. Sir James Simpson, before the proper treatment of this condition had been made simple by Dr. Braxton Hicks, and safe by Lord Lister, estimated the mortality of mothers with placenta previa at 1 in 4 or more. Now, with due care, it does

not exceed 1 in 20. Why this great difference? Why did the women with placenta previa fifty years ago die in such numbers? First of all, because no patient with placenta previa escaped internal examination, and no such patient was delivered without a wound. Before Lord Lister taught doctors and midwives how to procure asepsis by using antiseptics, many women with placenta previa died because they were infected with septic poison by the vaginal examinations. This ought not to occur at the present time, and it will not occur when women are attended in their confinement solely by persons acquainted with the use of antiseptics.

There are and always will be, so long as human intelligence remains imperfect, a few who die from hemorrhage before the child is born. This is usually because the doctor either is not sent for soon enough or cannot get to the patient quickly enough, or it may be the patient's friends are perverse, and will not send for the doctor at all, or will not let him act when he does arrive. Those cases are not usually due to any fault of the doctor.

The commonest cause of death, if the patient is not treated properly, and early, is postpartum hemorrhage. Hemorrhage before delivery exhausts the patient, so that a moderate amount of bleeding in the third stage of labor is more than the exsanguined patient can tolerate.

But the most common cause of death in the past lay in the pernicious maxim, "Deliver as quickly as possible." This often meant that the medical attendant tore open the cervical canal, either with his fingers or his hands or with some dilator, or with the fetal head in the grasp of forceps, and dragged out the child, whether the uterus was contracting or not. The tearing open of the cervix meant lacerations, the situation, extent, and direction of which the operator could not control; and the dragging out of the child while the uterus was passive was frequently followed by dangerous postpartum hemorrhage.

The path of safety is that laid down by Braxton Hicks, who in 1889 wrote that within the previous thirty years the mortality of placenta previa had been reduced from 30 per cent to somewhere near 5 per cent. He put the kernel of the matter thus:

"The early handling of these cases, and the general antiseptic management of midwifery cases, both before and after delivery, can rightly claim to have had much to do with these excellent results."

The first thing in the treatment of placenta previa is never to forget that a pregnant woman with the placenta implanted on the lower uterine segment is not safe until she has been delivered. Therefore as soon as the diagnosis has been made premature labor should be induced. The only reason that can be urged against the induction of labor in placenta previa is the danger to the life of the child—the danger of its being killed by pressure on the cord during delivery, a risk which depends on the mode of delivery, and the danger of its death within a few hours or days after delivery from its being unable to assimilate food and maintain its body heat. This is a real but only comparative danger—a danger when compared with delivery of a child at term in a normal pregnancy. The pregnancy is not normal, and the longer it is allowed to go on the greater the danger to both mother and child. Therefore we ought to accept the fact that safety to the mother involves risk to the child from its premature birth, and induce labor as soon as the diagnosis of placenta previa has been made.

The author has already said that plausible reasons can be given for plugging the vagina in hemorrhage from placenta previa which do not apply to accidental hemorrhage. But the reasons, though plausible, are not sound. He agrees on this point with Braxton Hicks—a man whose name in London ought to be, and will be, ever held in honor—who in 1889 wrote: "With regard to pressure by the tampon, I believe the general consensus in British midwifery is against its use, and with this I am in accord—partly because unless perfectly done, and this is difficult; it is of no use; and if perfectly done it is very distressing to the patient, especially if it be necessary. Still it has some advantages, because by distending the roof of the vagina we also dilate the os and provoke uterine action. But its action is tedious, and lacks the precision afforded us by the more recent methods."

In theory, of course, the doctor, when he goes to a case of labor, ought to be equipped with everything that can possibly be required. If some fatal or grave accident happens, and the doctor does not meet it with the best treatment, but when blamed pleads in extenuation of his fault that he had not the necessary instruments with him, he may be told that he ought to have had them. Books on obstetrical surgery assume that the accoucheur always has every instrument and drug at hand, for it is their business to teach the best thing, and not to describe makeshifts. Push this doctrine a little further, and apply it to every doctor on his daily round, and not only to the man in attendance on a labor, and you come to the principle that every doctor ought to carry about with him the wherewithal to perform every conceivable operation in surgery, which is absurd. There always will be emergencies in which the doctor has to do his best with his ten fingers and such adjuncts as can be carried in his waistcoat pocket. Supposing then a doctor with this scanty equipment is called to a case of placenta previa, a long way from his house, what should he do? He will find the cervix uteri dilated enough to admit his finger. If it is not he cannot as a rule make the diagnosis. It is true that placenta previa has been perceived by abdominal palpitation, but this has been only in exceptional cases and by exceptional hands. The diagnosis cannot be made by the ordinary man until the finger can pass the internal os and feel the placenta. The bleeding occurs because the os internum has begun to dilate. When dilation has begun the uterine contractions, which occur intermittently throughout pregnancy, tend to press the placenta into the dilating cervical canal. The placenta cannot move on without detachment of a small part of it bordering on the os uteri, and consequent bleeding from the several uteroplacental vessels. Local violence may bring about detachment of a placenta which is previa, but such cases are very rare, and cannot clinically be distinguished from accidental hemorrhage. The statement is true of nearly all cases of placenta previa, that when the doctor reaches them after having been sent for on account of hemorrhage, the cervical canal is open enough to

admit his finger. Being then able to pass his finger through the cervical canal, what is the doctor to do?

To settle this, let us first ask, What will happen if he does nothing? Let us assume that the case goes on favorably. The favorable cases are those in which the uterine contractions are vigorous and frequent. If such good uterine action is present, each contraction presses the placenta through the os internum and into the cervical canal, and in doing so tears through vessel after vessel, running from the uterus to the placenta. Each vessel, as it is torn through, bleeds. Each vessel, until it is torn through, is a hindrance to the proper dilation of the os internum, and the retraction of the lower uterine segment. The bleeding is stopped, first, by compression of the vessels, when the lower uterine segment is retracted, and then by thrombosis of the vessels. The successive hemorrhages weaken the patient; but if the labor has come on much before the full term of pregnancy the child will be small, and if the uterus acts powerfully the probability is that the child will be born before the patient has lost a dangerous amount of blood.

After delivery good uterine contraction and retraction will continue, and the third stage of labor will be accomplished without disaster. But there are many possibilities. The pains may be weak and few. Then from every vessel that is torn across there will be bleeding until uterine contraction occurs. The attachment to it of the placenta will hinder the expansion of the lower uterine segment, and disturb the polarity of the uterus, making the separation of the placenta slow, and prolonging the period of bleeding from the torn vessel. The best way in which the doctor can use his fingers is to pass his finger through the os internum(sweep it round, and separate the placenta all round as far as he can reach. With his one finger he cannot reach much more than an inch and a half from the os uteri. He can thus separate the placenta over a circular area of about 3 inches in diameter. By so doing he helps to restore uterine polarity—that is, he promotes the contraction of the body of the uterus and retraction of the lower uterine segment. But although he has done something to promote uterine contraction, yet it may be

slow in coming on, and the patient may lose a great deal of blood before retraction of the lower segment stops it, although not so much as if the case had been left to nature. The next thing for the doctor to do is to put two fingers through the cervix instead of one. This amount of stretching can be done so gently that the term "dilation" may be fairly applied to it. It is seldom that the middle of the placenta is exactly over the os internum. Usually when the doctor has stripped off the placenta all around as far as he can reach, he will at one place have come to the edge of the placenta.

When he has reached the edge of the placenta, he should rupture the membranes, seize the child's foot, and bring it down. To do this it will be necessary to still further gently dilate the cervical canal, so that it may allow two fingers, plus the child's foot, to pass through it. When the foot has been drawn through the cervical canal, the leg and thigh will easily follow it, and then the half breech comes to occupy the lower segment of the uterus. When this has been attained the accoucheur can control the hemorrhage by pulling on the leg. This should be done gently, with no more force than is necessary to stop bleeding, so that the cervix may be dilated, and not torn. For the avoidance of postpartum hemorrhage the child should not be dragged out when the uterus is not acting; the uterus should be allowed to expel it, and, if possible, the placenta. As these labors are, or ought to be, premature, the child will be small, and there will be no mechanical difficulty; the uterus can, and will, expel the child, although it may take some time about it. This is the method of treatment recommended by Braxton Hicks. It is the method by which safety can be insured for the mother in 95 per cent of cases of placenta previa, provided that it is carried out with strict antiseptic precautions. It is summarized in the words: Early turning, slow extraction, antiseptics.

But though this means safety for the mother, it is far from that for the child. The doctor who is about to carry out this treatment should always warn the parents that the interests of mother and child are in this condition antagonistic, and that it is his intention to act in the interest of the mother. Even if the

child is born living, it will be so small and feeble that there will be difficulty in rearing it, and it will very likely be suffocated during birth from prolonged pressure on the cord while the breech is slowly dilating the lower uterine segment.

However much we may think the march of invention has improved upon this method, yet cases will occur in which the need for treatment is urgent and the doctor has with him nothing but his hands. He must then either follow the simple method of Braxton Hicks, or let his patient go on bleeding.—*The Therapeutic Gazette*.

Extracts from Home and Foreign Journals.

SURGICAL

A DEATH FROM SALVARSAN.

Dr. Gaucher, professor of cutaneous and syphilitic diseases, Paris, reports the case of a young man, 19 years old, having an indurated chancre of the frenum, a month old, and a double indolent, inguinal adenopathy. He received an intravenous injection of 0.6 gm. of salvarsan. A quarter of an hour later he was seized with vertigo and a little later with vomiting and elevation of temperature. The next day his condition was normal. Two days later a new injection was made, which was followed by vertigo, headache and greenish vomiting, which vomiting persisted the next day and was accompanied by epigastric pain. The day after that in the afternoon the patient was seized with convulsions first tonic, then clonic epileptoid, with frothing at the mouth. At 4 o'clock he was in coma and died two hours later without having regained consciousness. At the necropsy all the organs except the kidneys were normal. The kidneys were increased in size, hard and congested. Microscopic examination showed lesions of acute nephritis with epithelial degeneration and tubular rupture. The patient had suffered a hyperacute arsenical intoxication and died of uremia caused by degeneration of the kidneys.—*Critic and Guide*.

A SIMPLE METHOD OF GIVING SALT SOLUTION PER RECTUM.

Here is what the Mayos have found to be the most satisfactory method of giving normal salt solution continuous per rectum. An ordinary glass irrigator is fastened one foot above the patient's mattress. A medium size soft rubber tube is connected to the nozzle and introduced three to five inches into the rectum. Three parts of moderately warm normal salt solution is poured into the irrigator jar. It is not necessary to use a thermometer to regulate the temperature of the solution. The nurse adds

more warm solution as necessary, testing the temperature of the solution with her fingers. The solution flows slowly into the rectum and is absorbed. Should the rectum become distended with fluid it produces a pressure on the solution, and it will flow back into the jar.

They have an attic full of fancy appliances for giving salt solution per rectum that they have discarded.—*St. Louis Medical Review*.

THE SURGICAL TREATMENT OF GOITER.

W. D. Hamilton, Columbus, Ohio, states that small parenchymatous goiters are cases for medical treatment; most others should be operated upon. Thyroid enlargements often contain nodules of new growth which should be recognized early and removed if one wishes to avoid the cardiac and pulmonary pressure symptoms. Iodine injected not only is not a specific, but also may cause firm adhesions which will render removal difficult. In Graves' disease the tumor should be operated upon as soon as the disease is recognized; one should not delay until severe symptoms, such as tachycardia, develop. Simple ligation of the vessels may be sufficient. Physical examination of the neck should always include a search for the thyroid gland. Early operation in most goiters will minimize the risks and give a better chance of relieving symptoms. Although most tumors of the thyroid are benign, one can never tell when symptoms of suffocation will arise.—*Medical Record*.

PRESENT STATUS OF SURGERY FOR CANCER OF THE BREAST.

Dr. E. S. Judd, of Rochester, Minn., said that tumors of the breast might be divided into two groups, benign and malignant. So far as was known, at the present time, a differentiation other than microscopic could not be made between a benign tumor and a very early malignant one. They should all come under the same line of treatment, namely, radical excision of the malignant tumors, and removal of the tumor followed by radical excision if the

growth proved malignant in the supposedly benign type. Age was no longer considered an important factor in determining malignancy. Handley believed that cancer originating in the breast disseminated through the lymphatics in the fascia, and that the embolic theory had been accepted chiefly because there was no proof against it. While it was true that the muscles were seldom involved, as compared to the fascia, at the same time he had recently observed several cases in which the lymphatics penetrating deep into the muscle were extensively involved. The frequency with which mammary carcinoma produced metastases in the bones was well known. The sternum and ribs were the most frequently involved, and this occurred by direct extension. The femur, bones of the spine and humerus came next in the order of frequency. It was often advisable in cases of cancer of the breast to have X-ray plates made of the bones most frequently invaded, since it was obviously useless to remove the breast should one of these bones be involved.

Two hundred and sixty-four cases of carcinoma of the breast had been observed in the clinics at St. Mary's Hospital within the past two years. Of this number, 200 were considered operable and sixty-four inoperable. In order to make an early, positive diagnosis, it was necessary to remove for macroscopic and microscopic examination all supposedly benign and doubtful neoplasms.

The technique of radical amputation of the breast has changed but little in the past few years. A large amount of skin, equidistant in all directions, should be removed. The most important part of the technique was the removal of a very extensive part of the superficial and deep fascias. This dissection should begin above the axillary structures, include the pectoral muscles and fascia of the axilla, and extend down over the rectus muscle, taking in a part of its fascia. In removing the pectoralis major the fascial incision was carried to the sternum and from there outward to the large muscles of the back. If there were any skin nodules, or if the integument was brawny and edematous, although the local lesion could be entirely removed, in all probability there were internal metastases or bone lesions, and the condition was hopeless.

The prognosis as to the probability of a cure in a case of carcinoma of the breast would depend (1) on the length of time the neoplasm had been developing; (2) on the degree of outlying involvement; (3) the activity of the gland which would be determined by the age of the patient, and the relation to a period of lactation, and (4) the thoroughness of the removal of the gland-bearing fascia.—*The Lancet-Clinic*.

OIL OF CAMPHOR IN PURULENT PERITONITIS.

Notwithstanding the great progress which modern surgery has made in the treatment of abdominal disease and the prophylaxis of peritoneal infection, purulent peritonitis remains, when once established, a very deadly malady. It is especially when acute disease of the vermiform appendix has been treated with insufficient promptness that this fatal complication remains familiar to the surgeon. Hence suggestions are heard from time to time urging the use of chemical agents, as well as saline irrigation and flushing of the peritoneum, which so often proves insufficient. Dr. Krecke, of Munich, recommends oil of camphor for this purpose and claims excellent results. He treated with complete success eleven cases of acute general purulent peritonitis, all resulting from perforation of a sloughing appendix. The time which elapsed between the development of peritonitis and the application of oil of camphor to the peritoneal cavity ranged from eight to eighty hours; the age of the patients from ten months to seventy years. The abdominal cavity was quickly opened, the appendix amputated, the pus wiped away, and then 10 cc, of a one-per-cent sterilized solution of oil of camphor was poured into the peritoneal cavity. It was carefully distributed over the whole area of the peritoneum by means of gauze sponges, etc. Then the abdominal cavity was closed and a rubber tube holding a strip of gauze placed in the wound.

Dr. Krecke advocates the use of oil of camphor as a prophylactic measure in all abdominal sections where the peritoneum is already infected. He read his report on the treatment of his eleven cases at a meeting of a medical society in Munich last

winter. In the discussion which followed, Dr. Schlafli stated that very strong solutions are in use at Basle. Professor von Herff introduced from 30 to 50 cc. of 10 per cent solutions of oil of camphor into the peritoneum in 53 cases where the peritoneum was infected before operation. All but one case recovered. Dr. O. Burckhardt has proved that streptococcal infection of the peritoneum in white mice after injection of oil of camphor seemed to be completely neutralized, although other infected mice not treated with the oil died rapidly with all the symptoms of fulminating peritonitis.—*British Medical Journal*, Sept 30, 1911. *The Therapeutic Gazette*.

PATELLA, TREATMENT OF FRACTURE OF

The following procedure is recommended by the author in this condition (*British Medical Journal*, July 29, 1911): First, a mold is made of the sound knee with poroplastic material, 1 1-2 feet long by 6 inches broad, which is softened in boiling water and then firmly placed on the knee. The mold of the sound knee cap thus taken is used as a splint for the fractured bone, the fragments being vised in the cap of the splint. A little cotton wool is placed in the cap; the rest of the splint, extending above and below the knee-joint, is also to be sufficiently padded. Before fixing the splint the fragments are strapped into position by adhesive plaster, longer strips being also placed just above and below the patella and drawn in contrary directions to pull the upper and lower fragments together. Lastly a plaster-of-Paris bandage is placed over all. In three weeks the plaster-of-Paris is taken off. The splint is kept on for two weeks more, passive exercises begun, and the knee-cap used for two months, after which it is discarded.—*J. T. MacLachlan, Monthly Cyclo-pedia and Medical Bulletin*.

HAIR PIN IN THE URETHA.

Dr. J. C. Kennedy presented the following case: Patient, age 60, suffered for some years from retentions of urine due to an enlarged prostate gland. Tiring of catheter life, he endeavored

to dilate his obstruction with a hair pin. Passing this instrument very deeply into the urethra, it suddenly slipped from his fingers and every effort on his part to recover it failed. He then went to his family physician who found it impossible to remove the hair pin, because the prongs were buried in the urethral mucous membrane on either side. The more he endeavored to pull it out the more he shoved it toward the bladder. On perineal section we found the blunt point partly in the bladder. The pin was removed, together with the prostate gland, both of which specimens were presented.—*Long Island Medical Journal*.

LOCAL ANAESTHESIA.

Dr. Wm A. Boyd reports in *Merck's Archives* for November, 1911, ten cases in which he utilized quinine and urea hydrochloride as a local anesthetic. He found that enough time for anesthesia to become complete should be allowed, and suggests that an interval of at least twenty minutes should elapse between the injection of the anesthetic and the operation. In his cases postoperative anesthesia lasted on an average three days, and he failed to observe any dermatitis following its use. The preparation exerted a decided hemostatic effect, causing, however, in the majority of cases, some induration, but which usually had disappeared at the end of three months.

The author concludes that any operation usually done with cocaine can be done with this anesthetic, adopting the same technic; also, that this agent is preferable to cocaine, as being less expensive—and, the abstracter wishes to add, presenting less danger of intoxication—*The American Journal of Clinical Medicine*.

THE SURGERY OF THE ABDOMINAL WALL.

Sir A. P. Gould states that the first points to be determined in any operation on the abdominal contents are the position and the extent of the incision. The incision should be, whenever possible and as much as possible, directly over the organ or lesion

which has to be dealt with internally. One should always think of the abdominal wall as one of the most important muscles of the body, and remember that the aim of the surgeon in operating through the abdominal wall should be to make such a wound as will not injuriously interfere with this muscular apparatus or will interfere with it as little as possible. Upon the integrity of the linea alba, therefore, depends the perfect function of the whole of the abdominal wall. Anything which weakens the linea alba is liable to cause much more apparent and more serious mischief than that which weakens other parts of the abdominal wall. In renal surgery, it is well in exposing the kidney not to make a transverse cut regardless of the direction of the fibers of the muscle in the loin. The incision should be oblique, and made parallel with the fibers of the external oblique muscle, and the surgeon should separate the fibers of this muscle, and should be careful not to cut the twelfth dorsal nerve.—*Medical Record*.

OBSTETRICAL

STERILITY IN WOMEN.

E. McDonald notes that 10 per cent of married women are sterile. Rich diet, indolence, and lack of exercise have a distinct effect in increasing sterility. The husband is responsible for the sterility in a quarter or more of all cases. Among the causes of sterility in women are imperforate hymen and vaginismus, infantilism of the genitalia, gonococcus infection, ovarian disease, misplacements of the uterus, perineal laceration, operations, chiefly curettage, fibroids, systematic diseases such as anemia, diabetes, syphilis and obesity, certain drugs, such as opium, and certain occupations, such as working in tobacco.—*Medical Record*.

END RESULTS WHEN HYSTERECTOMY HAS BEEN DONE AND AN OVARY LEFT.

Dr. J. O. Polak (Surg., Gyn. and Obst., July, 1911) from his study of this subject, concludes: First, that the technique of the

operation and the general health of the patient have much to do with the end results. Second, that a conserved ovary, if unhealthy, will leave the patient in a worse state mentally, nervously, and physically, than if a total extirpation had been made. Third, that when the woman is at the age at which the menopause should occur, or when she is past the menopause, a total ablation gives the best results. Fourth, that the nervous phenomena are more marked when the patient is operated on when she is in comparatively good health, with a high preoperative blood pressure, than when the blood picture shows anemia or toxemia. Fifth, that the symptoms of the operative menopause are less after extirpation for pelvic inflammation, than when the ablation is done for fibromyomata; this is probably due to the associated vessel changes which we find in fibrosis. And finally, that when one or both healthy ovaries can be conserved it should be done; the younger the patient the more necessary the conservation.—*The American Practitioner and News.*

THE FATE OF THE PREMATURELY BORN.

Wallich and Fruhinsholz have applied in their research what they call the centrifugal and centripetal methods, that is, both ascertaining the later history of the prematurely born infants, and tracing back to birth the history of older children or adult parents. The earliest known history of the kind is that of a professor at Padua in the sixteenth century who was born at the seventh month and lived to be 80. Among other famous "prematures" mentioned are Newton, Rousseau, Voltaire, Cuvier, Victor Hugo, Lamartine and Renan. The compilations that have been published on the subject are reviewed and a personal compilation tabulated, including 143 infants born before term of presumably healthy parents, and whose history has been traced into adult life. The outcome is shown to depend in large measure on the weight at birth, that is, the degree of development. Of seventeen infants weighing from 900 to 1,500 gm., 41.1 per cent have developed into normal adult life and a similar percentage are only slightly handicapped (*avenir laissant a desirer*), while

the rest are much below the normal standard; of the 25 weighing from 1,500 to 2,000 gm. 52 per cent are normal and 36 slightly handicapped; of the 36 between 2,000 and 2,500 gm., 75 per cent are normal and 22.2 per cent slightly handicapped, while of the 65 weighing between 2,500 and 3,000 gm. 78.4 per cent are normal and 20 per cent only slightly handicapped. Among the total twenty-seven slightly handicapped infants, trauma from an obstetrical operation may have co-operated in eleven cases; five other infants were the first born. Tracing back to history to birth of 1,804 in Broca's children's surgical service, and of 620 inmates of the asylum for epileptics and feeble-minded, showed that over 12 per cent of the former and over 8 per cent of the latter are known to have been prematurely born. A large proportion of the prematurely born are thus shown to develop normally both in mind and body, while others present various signs of degeneracy, hernia, club-foot, incontinence of urine and nervous disturbances, these signs of degeneracy apparently linked with the earliness of the birth and the violence of the obstetrical trauma. On the other hand, the research shows a large proportion of prematurely born among the degenerates in institutions, and that degeneracy in general is traceable as a rule to syphilis or alcoholism in the parents or to the earliness of the birth and the fact that the infant was the first born. The author's final conclusion is the importance of refraining from bringing on the birth before term by overwork or trauma from sexual intercourse. —*The Journal of the American Medical Association.*

ATROPINE IN UTERINE HEMORRHAGE.

September 16, 1911, I was called to see Mrs. W., aged 35, mother of six children. Two and a half years ago she had an operation for cyst of the spleen and pancreas. Eighteen months ago she gave birth to a boy, now living. Last menstruation occurred July last. On the date named I was called on account of "flooding." Whether she had an abortion or it was simply a case of menorrhagia I could not determine. I found the bed soaked with blood; patient pulseless, cold extremities; clammy

perspiration, nausea, vomiting of bilious matter, pupils dilated to extreme size, periods of unconsciousness, thought she was dying.

I gave hypodermically, glonoin, gr. 1-100, and strychnine sulphate, gr. 1-50, and after ten anxious minutes could feel the pulse plainly. I then gave atropine sulphate, gr. 1-100, which dose I had to repeat in thirty minutes. An hour after the first dose of glonoin I gave a second 1-100 grain, with atropine, 1-100 gr. I also injected 2 ounces of normal saline solution subcutaneously, as the flow had stopped, yet fearing dissolution from loss of blood.

The patient now complained of dryness of mouth, extremities began to get warm, the clammy skin became dry, and I felt the victory was won. I saw her six hours later (having already been with her five hours), and found her in good condition, but weak. Needless to say, the uterus was flushed, besides other measures, but to no avail in checking the hemorrhage until the atropine was given. These seem like enormous doses, but I deemed them necessary, and results proved I was right. The patient steadily improved.—*The American Journal of Clinical Medicine.*

PREGNANCY IN A WOMAN OF FIFTY.

C. C. Norris, Philadelphia (*J. A. M. A.*), reports the case of a woman, aged 50, who had been twice married but had had no children, though she had been operated on after each marriage by dilation and curetting and simple dilation of the cervix without results. Menstruation had continued, usually with but slight discomfort. She had never had severe dysmenorrhea. The genital organs were rather normal though the os was small. Dilatation was performed and a rather thick Wiley drain inserted ten days before the expected monthly period. The Wiley drain is a sort of grooved-stem pessary. Pregnancy followed, with normal labor and delivery. The advanced age is of interest in this case, though menstruation is not uncommon after the age of 50.—*Critic and Guide.*

MEDICAL

THE MEDICAL TREATMENT OF HYPERACIDITY.

Roubitschek (*Deutsch. Med. Woch.*, 1911, xxxvii, 874) advocates hydrogen peroxid in cases of indigestion due to hyperacidity. Roubitschek found that fluid preparations were much more satisfactory than the solid preparations that are recommended by some. He first gives about 300 cc. of a one-half per cent solution three times a day before meals. If no result is obtained from this, the strength of the solution is increased to three-quarters of one per cent. The disadvantage of the stronger solutions is that they are apt to cause vomiting, and solutions stronger than one per cent are almost sure to do this. The results were extremely good in eighty per cent of the cases treated. The average length of treatment was fourteen days. The permanent results achieved by this method of treatment are somewhat obscured by the fact that the patients were only under observation for a period of three months after the treatment. However, during this time the patients remained free from symptoms, and Roubitschek cites a case reported by Poly who was perfectly well one and a half years after treatment.—*New Orleans Medical and Surgical Journal*.

TREATMENT OF DYSPHAGIA IN TONSILLAR INFLAMMATION.

T. Hald reports (*Ugeskrift for Laegar*, April 6, 1911, p. 485) the results he has obtained by cutaneous compression in 46 cases of inflammation in or near the tonsils. The troublesome dysphagia so frequently associated with this condition may be often relieved by firm digital compression in the neighborhood of the external ear. This manoeuvre, applied at meal-times relieved or completely banished pain on swallowing in 32 cases; but as digital compression was tiring and troublesome, the writer devised a simple instrument which can be fitted on to the patient's head at meals. He found two areas, over each of which pressure could be effectively applied in a certain number of cases.

One of these is situated at the posterolateral aspect of the external auditory meatus, and it is most readily reached by pressing upon the tragus so as to close the external auditory meatus. The other area is situated behind the ear, over the upper portion of the mastoid process. In some cases pressure over both areas was equally effective, while in others pressure on only one or other of these areas gave relief. The benefit which the patient derives from this treatment can be scarcely attributed to suggestion, as compression of other cutaneous areas, such as the skin of the forehead, is valueless. Nor is the effectiveness of compression of the tragus due to the closure of the external auditory meatus, and the subsequent pressure put upon the membrana tympani for the action of tragus compression is not affected by the insertion of a glass tube, open at both ends, into the external meatus.

The writer gives the following explanation of the above phenomenon: The tonsils and the cutaneous areas mentioned are derived from tissues which are in close proximity in the embryo. Consequently, there is an intimate correlation in their nerve supply, and irritation of the cutaneous areas is therefore capable of inhibiting impulses which normally convey the sense of pain from the throat. (*British Medical Journal*, Aug. 5, 1911.)—*The Therapeutic Gazette*.

RENAL TUBERCULOSIS.

Professor Barth (*Deut. med. Wochensch.*, No. 21, 1911) has investigated the end results in 37 of 40 cases of renal tuberculosis treated by nephrectomy. Of these 12 were cured and 12 improved or still under treatment, while 13 died. The period of observation of cases termed cured ranged from one and one-third to nineteen years. A comparison of these results with those obtained in about the same number of cases not subjected to operation shows that the prognosis in the latter was far less favorable. From his studies Barth draws the following conclusions: So long as the disease is confined to one kidney and its ureter nephrectomy affords very favorable prospects of a permanent cure.

If the bladder is already affected, a complete and lasting cure of the tuberculous process can be expected only in a fraction of the cases, approximately one-fourth. About the same number succumb in the first year to tuberculosis, while in the others a more prolonged improvement can be anticipated. In five of the author's cases of renal and vesical tuberculosis treated by operation improvement persisted for $1\frac{1}{4}$, $1\frac{1}{2}$, $1\frac{3}{4}$, 2 and 9 years, while five others died after 2, $3\frac{1}{2}$, 5 and $9\frac{1}{2}$ years of the renal disease or other tuberculous involvement. Even after a complete cure has resulted in tuberculosis of the bladder, various disorders are apt to persist, such as frequent urination, especially at night, and for this reason every case of recognized renal tuberculosis should be nephrectomized, if possible, before the bladder has become involved.—*The American Practitioner and News.*

TUBERCULOSIS IN CHILDREN, DIAGNOSIS OF.

The intracutaneous tuberculin test is considered by the author to present many advantages over other diagnostic tuberculin reactions. It is relatively easy to carry out, the result of the test is readily recognized, and the discomfort to the patient minimal. The amount injected can be accurately gauged. The possibility of injecting different strengths and even a high concentration of tuberculin by this method renders the test available in all cases of tuberculosis. The subcutaneous test fails in patients with fever, while the cutaneous reaction fails in cases where the susceptibility of the organism to tuberculin has been reduced through acute infections or cachexia; the intracutaneous method, on the other hand, succeeds in all these cases. It is thus, in many instances, the only procedure to be depended upon. In patients morbidly in dread of tuberculosis(this test, if strong concentration cause no reaction, will definitely eliminate any possibility of the presence of the disease. The case of a cachectic child with meningitis in which tuberculosis was ruled out by means of this test is cited by the author. He injected 1 drop of a 1-1000 solution of old tuberculin, and, if no reaction follows, increases the strength to 1 per cent, 10 per cent, and even sometimes 100 per

cent, some cases finally reacting to the last-named dose. S. Engl (Deutsche medizinische Wochenschrift, September 7, 1911).—*Monthly Cyclopaedia and Medical Bulletin*.

HICCOUGH TREATMENT.

In severe cases following procedures may be resorted to: Lavage, passage of esophageal sound, prolonged pressure over abdomen and epigastrium, forcible traction of tongue, abdominal massage, constriction around lower thorax, cold or hot pack, blisters to each side of cervical spine over roots of third, fourth and fifth nerves. Following remedies have been used: Musk, nitroglycerin, amyl nitrite, spirit of chloroform, asafetida, spirit of camphor, tincture of capsicum, tincture of valerian, cocaine, codeine, bromides, jaborandi. Ether narcosis best in hysterical cases. Where hiccough persists to point of exhaustion, give following by rectum: Potassium bromide, ʒj (4 Gm.); tincture of opium, fʒss (2 c.c.); water, enough to make fʒviij (240 c.c.) Kink.—*Monthly Cyclopaedia and Medical Bulletin*.

INDICATIONS FOR ABDOMINAL CESAREAN SECTION IN ECLAMPSIA.

Dr. John F. Moran, of Washington, D. C., reported four cases of eclampsia, which occurred in two patients he saw in consultation, in which Cæsarean section was performed, saving both mothers and all of the children. The first patient, a primipara, eight months gestation, frequent convulsions, cervix intact, was operated upon by Dr. I. S. Stone, and the second was operated upon at term under like conditions, in three successive labors, by Dr. W. P. Carr.

Kellitz, in 1897, collected twenty-eight cases of eclampsia operated upon by Cæsarean section with a maternal mortality of 50 per cent and an infantile mortality of 62 per cent. Streck-eisen, in 1903, collected twenty-eight cases, twelve mothers died, and sixteen recovered.

THE EFFECT OF PALUDISM ON PREGNANCY, LABOR AND THE PUERPERAL STATE.

Laffont finds that the malarial fever has a marked effect throughout and after pregnancy. It may be transmitted from the mother to the fetus. Abortion or premature labor is very likely to result. Fetal paludism is proven by finding the parasites in the fetal blood. In some cases it produces deformities of the fetus; in most cases the child is weak and underweight. Hereditary paludism may be latent for some months, or may at once produce characteristic paroxysms. It is more likely to be transmitted during the last three months of pregnancy. If it is to recur in the mother after labor it will generally appear within ten days; it may cause hemorrhage either at or after labor. There is inertia uteri and artificial delivery is often necessary. The disease may become pernicious in the mother, though as a rule its course is benign. The secretion of milk is modified and may be suppressed; it does not transmit the parasite. Malaria following labor is not generally typical in form. Quinine is the best treatment for it.—(*L'Obstetrique.*) *Medical Record.*

PREGNANCY AND CARDIAC DISEASE.

Rosenthal reports two instructive cases of this association. In the first labor was followed by acute cardiac insufficiency resulting from the mitral valvular lesion. The child was extracted by means of colpohysterotomy, narcosis being contraindicated. The striking feature of the case was the nonresponse of the heart to the action of roborants. She had gone through several labors successfully with the mitral lesion present. She recovered from the present labor and left the clinic with good compensation. In the second case it was not labor *per se* but labor with twins of unusual size which precipitated a crisis in the gravida with vitium cordis. This patient was also delivered by means of anterior colpohysterotomy without narcosis.—*Medical Record.*

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at \$1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

WHEN MAY A MAN USE HIS MUSCLE?

A medical man practicing in West Ealing, England, had occasion to remonstrate with the husband of a female patient on the ground that his conduct had caused injury to her health. This was resented by the husband to such an extent that many months after he summoned the man to his house by telephone, and having him there, barred his exit and tried to enforce a retraction and an apology. The medical man refused to do either, and after being called abusive names was forced to throw the husband on a couch to gain an exit from the house. For this he was arrested for assault. The judge, after hearing the testimony of the prosecution, said that the only question was whether the defendant used only such force as enabled him to leave the house. Being of the opinion that he had not exceeded this, he dismissed the case. It is remarkable that we are so seldom required to record such resentment on the part of husbands to strictures from medical men.

E. S. M.

SPECIAL WESTERN NUMBER.

In furthering the plan of producing special issues of the *American Journal of Surgery*, composed of contributions by surgeons residing within a certain geographical area, yet of international

reputation, there will be issued in the early part of 1912 a Special Western Number of this magazine.

Subjects and those to contribute: "The Operation of Gastroenterostomy," by William J. Mayo, Rochester, Minn. "The Surgery of Tendons," by John B. Murphy, Chicago, Ill. "Operative Treatment for Graves Disease," by George W. Crile, Cleveland, Ohio. "Colonic Intoxication," by J. E. Binney, Kansas City, Mo. "Practical Points in the Surgical Treatment of Exophthalmic Goitre," by A. J. Ochsner, Chicago, Ill. "Treatment of Foreign Bodies in the Esophagus," by E. Fletcher Ingals, Chicago, Ill. "Brain Surgery Technique," by J. Riles Eastman, Indianapolis, Ind. "Treatment of Abscesses and of the Necrotic Foci Resulting from the Use of Salvarsan," by A. Ravolgi, Cincinnati, Ohio. "Treatment of Prostatic Obstructions," by E. O. Smith, Cincinnati, Ohio. Subject not announced, H. Tuholske, St. Louis, Mo. "Artificial Tendons and Ligaments in the Surgical Treatment of Paralysis," by Nathaniel Allison, St. Louis, Mo. "Uterine Cancer," by John C. Murphy, St. Louis, Mo. "Arthritis Deformans," by Leonard W. Ely, Denver, Colo. "Acute Angulation and Flexure of the Sigmoid, as a Causative Factor in Epilepsy, with Special Reference to Treatment," by W. H. Axtell, Bellingham, Wash.

The character of contributions prepared by these well known surgeons are of such a nature as to make this number particularly interesting.

NEW YORK SKIN AND CANCER HOSPITAL, SECOND AVENUE, CORNER 19TH STREET.

The Governors of the New York Skin and Cancer Hospital invite the medical profession to attend a lecture by Dr. De Keating Hart, of Paris, on "The Fulguration Treatment of Cancer," on Monday evening, December 4, 1911, at 8 o'clock, in the outpatient hall of the hospital. The lecture will be illustrated by stereopticon pictures and charts. On the following mornings of the week there will be practical demonstrations on patients, of the new fulgurating apparatus of the hospital. Cards of admis-

sion to the latter will be issued by the Research Committee on request to Charles C. Marshall, Chairman of Executive Committee.

DR. CHARLES E. DE M. SAJOURS, SUPERVISING EDITOR OF THE NEW YORK MEDICAL JOURNAL.

We have the honor to announce that beginning with issue of December 9, 1911, Dr. Charles E. de M. Sajous, of Philadelphia, becomes the Supervising Editor of the *New York Medical Journal*. While Doctor Sajous will give up his private visiting practice, he will continue his work as consulting physician, investigator, teacher and author, and thus be in a position to keep in the closest touch with the needs of the medical profession.

Though born under the American flag, Dr. Sajous received his preliminary education in France. He studied medicine in Philadelphia, graduating with honors from the Jefferson Medical College in 1878. He served for two years as resident physician in the Howard Hospital, and in 1881 was appointed professor of anatomy and physiology in the Wagner Institute of Science, lecturer in the Philadelphia School of Anatomy, and clinical assistant in the laryngological department of Jefferson Medical College, succeeding Dr. J. Solis-Cohen, in 1883, as clinical lecturer and chief of that department. In 1891 Doctor Sajous went to Paris, where he devoted six years to original research. Upon his return, he was appointed Dean of the Medico-Chirurgical College. At the recent reorganization of the medical department of Temple University Doctor Sajous accepted the chair of pharmacology and therapeutics, which he still holds.

The immediate outcome of Doctor Sajous' six years of research work in Paris was the publication of two volumes on "Internal Secretions and the Principles of Medicine," a work which gave the author high standing as an original investigator.

Doctor Sajous has had a wide editorial experience, having founded in 1888 the *Annual of the Universal Medical Sciences*, which he conducted with the collaboration of some of the most eminent physicians in America and Europe, until the publication

was abandoned in 1893. The *Annual* had a circulation of over 5,000,000 volumes and the *Cyclopedia of Practical Medicine*, founded by Doctor Sajous in 1898 to succeed the *Annual*, and intended more particularly for the general practitioner, has attained a circulation of 240,000 volumes, the seventh edition being now in course of preparation.

The value of Dr. Sajous's services to medical science has been recognized in France by his being made a member of the Legion of Honor, while in Belgium he received the order of Leopold and was made a Knight Commander of the Liberator, besides receiving other titles, both governmental and scientific. In America Doctor Sajous has been president and vice-president of many societies and is a fellow of the College of Physicians of Philadelphia, and of the American Philosophical Society. He brings to bear on the editorial problems of the *New York Medical Journal* a brilliant and well informed mind, wide experience and a thorough knowledge of the needs of the American physician.

The publishers of the *New York Medical Journal* feel that they as well as its readers are to be congratulated upon having obtained the services of Doctor Sajous. Comprehensive and well directed plans have been formulated for enhancing the value and interest of the *New York Medical Journal*, and in carrying out these plans no pains or expense will be spared to give to our readers a medical journal of unprecedented authority and interest.

UNIVERSITY MEDICAL COLLEGE OF KANSAS CITY SENDS
GREETINGS.

It is the object of the trustees of the University Medical College of Kansas City, Missouri to submit to you a project which, if carried into effect, would be of mutual advantage to your university and to our college. Briefly stated, it is that the students of medicine in your university take the first two years of didactic and laboratory anatomy, physiology, chemistry, materia medica, therapeutics, etc., and then come to our school for their junior and senior years, which embrace medicine and clinical medicine,

surgery and clinical surgery, ophthalmology, otology, nervous and mental diseases, diseases of women and clinical gynecology, dermatology, syphilo-dermatology, diseases of children, medical jurisprudence, materia medica, therapeutics, obstetrics and clinical midwifery, radiology, electro-therapeutics, pathology, bacteriology, laryngology, orthopedic surgery, anesthetics, life insurance examinations, rectal surgery, necropsy, diseases of the stomach, intestines, etc.

Such an alliance would not only save the State a vast expense, but would give to your students better advantages than it would be possible for them to obtain in a small city with limited clinical material. It is the opinion of many educators that if the State gives her youth a high school education, this is fairly liberal, and more especially if the tax payers supplement this with a four years' college training. It was President Elliot, of Harvard, I believe, who said that if a student wants to go further than the preparatory school in his studies for a college course he should pay tuition. It is thought by tax payers in general that after providing a university course such as is necessary to secure the degree of A.B., it is an injustice to be compelled to make a large appropriation to equip and maintain a medical college for a mere handful of students when they can get better advantages at a small cost in a special clinical school such as we offer at the University Medical College. All students coming from your State, who do not possess the requisite knowledge will be advised to return to your university to acquire their necessary credits. Your students will be given credit on our diplomas for the work done or time spent with you. If such an alliance could be brought about it would work a saving of thousands of dollars to the State annually; but the principal advantage would be to the student, for our school is a clinical college taught by men of practical experience, not theoretical where the knowledge is given largely from text-books, as is oftentimes the case in institutions in smaller towns where clinical advantages are not obtainable.

We would be glad to meet you and discuss such arrangements as would be of mutual advantage.

STATUE TO FLORENCE NIGHTINGALE.

London has resolved to give a memorial to Miss Florence Nightingale. At a meeting held recently at the Mansion House it was decided that the memorial was to take the form of a statue, the remainder to be applied to the foundation of an annuity for nurses disabled by illness or age. The government has granted a statue site immediately opposite the Guards' Crimean Memorial, the most appropriate site in all London for a statue of "The Lady with the Lamp." It is unthinkable that the memory of Florence Nightingale and her great work should not be perpetuated for all time, and that, too, in the capital of the country for which she did so much. It is not to be gainsaid that Miss Nightingale would much prefer to have the whole sum applied to the benefit of nurses who have fallen into misfortune. A statue is one of the penalties of greatness, and let us not gainsay it. The statue will be honored more than Miss Nightingale and the rising generation need something to remind it of what the great dead have done for them. Subscriptions to the fund should be made to the Nightingale Fund, St. Thomas Hospital, S. E. London, England. *The Nursing Times*, St. Martin's Street, West London, has taken the opportunity to issue a fine portrait of Miss Nightingale for the sum of five shillings.—E. S. McK.

The American Red Cross desires again to invite attention to the exhibition in connection with the Ninth International Red Cross Conference, which will be held in Washington, D. C., from May 7 to 17, 1912.

The exhibition will be divided into two sections, which will be styled Marie Feodorovna and General. The former is a prize competition, with prizes aggregating 18,000 rubles, or approximately \$9,000, divided into nine prizes, one of 6,000 rubles, approximately \$3,000; two of 3,000 rubles each, and six of 1,000 rubles each.

The subjects of this competition are as follows:

1. A scheme for the removal of wounded from the battle field with the minimum number of stretcher bearers.

2. Portable (surgeons') washstands, for use in the field.
3. The best method of packing dressings for use at first aid and dressing stations.
4. Wheeled stretchers.
5. Transport of stretchers on mule back.
6. Easily folding portable stretchers.
7. Transportation of the wounded between warships and hospital ships and the coast.
8. The best method of heating railway cars by a system independent of steam from the locomotive.

9. The best model of portable Roentgen apparatus, permitting utilization of X-rays on the battlefield and at first aid stations.

The maximum prize will be awarded to the best exhibit, irrespective of the subject, and so on.

The General Exhibit is again divided into two parts. The first will be an exhibition by the various Red Cross Associations of the world. The second will be devoted to exhibits by individuals or business houses of any articles having to do with the amelioration of the sufferings of sick and wounded in war, which are not covered by the Marie Feodorovna Prize Competition for the year. While the American Red Cross will be glad to have any articles pertaining to medical and surgical practice in the field, it is especially anxious to secure a full exhibit relating to preventive measures in campaign. Such articles will be classified as follows:

1. Apparatus for furnishing good water in the field.
2. Field apparatus for the disposal of wastes.
3. Shelter, such as portable huts, tents and the like, for hospital purposes.
4. Transport apparatus (to prevent the suffering of sick and wounded) exclusive of such apparatus as specified for the Marie Feodorovna Prize Competition.

As with the Marie Feodorovna Prize Competition, for this country only articles having the approval of the Central Committee of the American Red Cross will be accepted.

Diplomas will be awarded for exhibits in this section of the exhibition as approved and recommended by the jury.

Further information may be obtained from the Chairman, Exhibition Committee, American Red Cross, Washington, D. C.

It is perhaps to apparatus having to do with prevention of disease in armies that the energies of Americans have been specially directed since the Spanish-American War. Therefore, the last-mentioned section of the Exhibition should make an appeal to them.

Obituary

DR. WM. A. ATCHISON.

This eminent physician, the Nestor of the medical profession of Nashville, died suddenly in his office while sitting at his desk opening his morning mail. Dr. Atchison was in his 81st year, the last 36 of which he had spent in the practice of medicine in this city. Dr. Atchison began the study of medicine in his native town, Bowling Green, Ky., and was a student in the private anatomical class of the late Dr. William T. Briggs, then living in that city. Dr. Atchison attended lectures in Louisville and graduated from the Medical Department of the University of Louisville in 1852. He began the practice of medicine in Warren County, Ky., near Bowling Green, and was esteemed the leading physician in his own community where he lived and engaged in the laborious pursuit of his chosen profession. In 1875 he moved to this city and established himself in an office with his uncle, the late Dr. Thos. A. Atchison. He was unusually successful in every sense of the word, and was thoroughly esteemed by his clientele and by his professional confreres. Dr. Atchison was a physician of the old school, but was progressive and completely alive to the progress of scientific medicine and was quick to take hold of anything that promised good to his patients. He was a member of the various societies of the city and of the American Medical Association. His skill as an accoucheur was well known and recognized by his associates. His personality was strong and he attached to himself a host of friends and admirers who sincerely deplore his death. He was thoroughly and conscientiously religious and was an officer in the First Baptist Church of this city. A devoted husband and affectionate father, he was bereaved in the death of his wife and two children at different times before his death, and in spite of these losses, which left him almost alone in the world, he bravely pursued his daily work. a pathetic yet noble and dignified figure. He was loved by all who knew him, respected by all with whom he came in touch.

He was a good physician, a truly devout Christian and a noble, upright, honorable man. He lived a long life of unblemished purity, and died after living a life of unselfishness and noble deeds. His life should serve as a model to succeeding generations and the memory of this good man should be cherished always by those who knew him and loved him.

Reviews and Book Notices

Physician's Year Book.—Being a Daily Memorandum, together with a Miscellaneous Jumble of Facts and Suggestions of Interest and Assistance to the Physician, "as the Days Fly By." 1912. Compliments of M. J. Breitenbach Co., 53 Warren Street, New York.

We acknowledge with thanks to the distributors the receipt of a copy of this useful memorandum book: It contains quite a fund of useful everyday information, and its blank pages will serve as a memoranda for every day of the year. It is compact and of convenient size for the pocket.

Physician's Pocket Account Book—Taylor.

This neat little gem of a book has appeared for 1912 with some additions and improvements. It is simplicity, neatness and efficiency itself. Above this it is legal, and can be taken into court, which cannot be said of all systems. It contains valuable information as to bookkeeping, fees and the collection of the same, the making of wills, saving and investing, poisons, weights and measures, periods of incubation of infectious diseases, and so on. Published by the Medical Council Company, Forty-Second and Chestnut Streets, Philadelphia, Pa.

Progressive Medicine. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; one time Clinical Professor of Diseases of Children in the University of Pennsylvania; Member of the Association of American Physicians, etc. Assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia; Ophthalmologist to the Frederick Douglass Memorial Hospital; Instructor in Ophthalmology, Philadelphia Polyclinic Hospital and College for Graduates in Medicine. Vol. IV. December, 1911. Diseases of the Digestive Tract and Allied Organs, the Liver, Pancreas and Peritoneum—Diseases of the Kidneys—Surgery of the Extremities, Shock, Anesthesia, Infections, Fractures and Dislocations, and Tumors—Genito-Urinary Diseases—Practical Therapeutic Referendum. Lea & Febiger. Philadelphia and New York. 1911.

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We take pleasure in calling the attention of our readers to the December number of this excellent quarterly. It is fully up to the standard of former numbers and carries out the intentions of its editors in an unsurpassed manner. The contributors to the different numbers have been selected for their especial aptness for the work in hand, and as a result its subscribers are treated to the newest and most advanced views upon the subjects of which it treats. The contents and contributors of this number are as follows: "Diseases of the Digestive Tract and Allied Organs, the Liver, Pancreas and Peritoneum," by A. S. Lannom, M.D.; "Diseases of the Kidneys," by John Rose Bradford, M.D., F.R.C.P., F.R.I.; "Genito-Urinary Diseases," by Charles W. Bromey, M.D.; "Surgery of the Extremities, Shock Anesthesia, Infectious Fractures and Dislocations and Tumors," by Joseph C. Bloodgood, M.D.; "Practical Therapeutic Reverend," by H. R. M. Landis, M.D.; Index. For the general practitioner we regard this quarterly as the most valuable of all such publications. It presents with appropriate comment the latest views upon all the selected subjects of which it treats, and gives a comprehensive picture of the advanced researches by workers all over the world. Every physician desirous of keeping in the van of the profession should avail himself of the opportunity furnished by this quarterly by becoming a subscriber.

Publisher's Department

"The recent reports by Menzer, a surgeon in the German army, tend to discredit the too implicit faith placed in the use of the salicylates alone in acute articular rheumatism. It is not denied that the salicylates pushed to effect will alleviate the symptoms, but he asserts that cases so treated are more subject to relapse and to permanent deformity than are those in which other remedies are exhibited, and that there should be incorporated with the salicylates other agents which will not encourage injurious complications."

The usefulness of good Hypophosphites in Pulmonary and Strumous affections is generally agreed upon by the Profession.

We commend to the notice of our readers the advertisement on page eight of this number. "Robinson's Hypophosphites" is an elegant and uniformly attractive preparation; the presence of quinine, strychnine, iron, etc., adding highly to the tonic value.

C. V. Mosby Medical Book & Publishing Company offers a work on Pellagra that should rapidly become popular at this time of widespread interest in this disease.

J. Stevens Arms & Tool Co. have an advertisement in the JOURNAL that calls attention to its unrivalled firearms. From personal use of the repeating shotgun we can speak favorably of the output of this company.

Fellows' Syrupum Hypophosphitum has long been a standard preparation with the profession, and it deserves the highest encomiums for its efficiency.

The Cincinnati Sanitarium is one of the best known hospitals in the United States for the treatment of nervous diseases and

drug habits. Patients all over the country are witnesses to the value of this hospital as a house of refuge for the unfortunate.

The preparations of Battle & Co., Eschol and Iodia, are well known wherever medicine is practiced, and all the preparations of this reliable house are endorsed by physicians generally.

Hydroleine, the advertisement of which has long occupied the cover of the JOURNAL, is an excellent and palatable preparation of cod liver oil which should be greatly in demand at this season of the year.

Listerine is unrivalled as an antiseptic preparation, as useful in the toilet as in surgical antisepsis.

Beechhurst Sanitarium enjoys a high standing among institutions for the treatment of nervous diseases and drug addiction.

Sanmetto is a preparation that gives the best results when administered in the treatment of prostatic inflammation.

Glyco-Thymoline is an exceptionally good agent in the treatment of all catarrhal conditions.

Theo. Tafel Co. is a reliable house where physicians can get everything in the way of instruments, braces, etc. needed in the physicians' armamentarium.

We have an X-ray outfit as furnished by the Sam J. Gorman Co., of Chicago, and can say that it has given universal satisfaction.

Neurosine is a standard preparation that is unequalled as an elegant form of treatment for all nervous conditions.

THE TREATMENT OF CONVULSIONS IN INFANTS.

BY HARRY TYLDESLEY, M.D.

One of the most frequent morbid conditions encountered in the treatment of the diseases of child life is convulsions.

The treatment of convulsions very naturally resolves itself into two indications—the removal of the cause and the institution of those measures—which relieve the congestion of the brain.

A study of the case in hand will reveal the causative influences and suggest those remedies that are indicated to remove the cause. Where the stomach is full of indigestible foods it must be emptied, and in a like manner other remedial measures must be addressed to the removal of the cause.

It is highly important that the physician go to work with the most earnest efforts to relieve the convulsive seizure. The inhalation of chloroform is useful in some cases. It should be given until there is no convulsive movement. I put all infants as soon as I see them in a bath of warm water, and give them a dose of Neurosine. This agent speedily overcomes the congestion of the brain and the child falls into a peaceful sleep from which it usually awakens with a clear head and no tendency to convulsions. Besides this Neurosine contains no opium, chloral or morphine, and it is, therefore, admirably suited to these cases. .

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NASHVILLE JOURNAL — OF — MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

VOL. CVI.

FEBRUARY, 1912.

No. 2.

Original Communications

STATE BOARD EXAMINATIONS.

BY W. T. BRIGGS, M.D., NASHVILLE, TENN.

State board examinations though a comparatively recent product of legislative activity have already done something toward raising the standards of medical schools. The mere existence of such examinations is bound to have a salutary effect, and because of these examinations many diploma mills have been compelled to close down, but have the examinations per se helped to raise the standard of medical education? Would not some law requiring four years in some reputable medical school do just as much good as these examinations do, without requiring this additional expenditure of time and money on the part of the recent graduate?

We feel that however much these examinations have done, they have not yet reached the point where they carry out the purpose for which they were instituted. This statement does not refer to the examinations of any one or any group of States, but to almost every State in the Union. It seems the greatest good these examinations have done is that the four-year course is insisted on before a graduate can lawfully practice, and in some States, among them Tennessee, there is no such requirement, since a student, after three years in a medical school, can practice, provided he passes the examination satisfactorily, for several months

before his temporary license is null and void. After his fourth year he is given a license without further examination.

If anything ever were inconsistent it is such a law as this, requiring four years in the medical school before allowing a permanent license, and yet giving a temporary license after three years have been passed in the school. It seems that if the applicant is allowed to practice one day he should be allowed to practice until his death without any more schooling or examinations. If men can prepare in three years to pass the State Board, then the college course should be three years, or the State Board of Examiners should raise their standard of examination. While the student-doctor holds this temporary license he might through ignorance cause a death. Likewise he might do the same after one more year of study, but as he is duly qualified that can not be helped. I said duly qualified, but that statement must be modified to read, duly qualified according to the State Board examination. This leads us to the discussion of the weaknesses and shortcomings of most of the State Board examinations. Wherein do they fail to answer the purpose for which they were instituted? In several ways:

First.—In most of the States the examination is a written one and there is little practical about it.

Second.—They do not raise the standard of the medical schools, inasmuch as it would not be difficult for any high school graduate to cram up for two years, even less, and pass the examination. Under such circumstances the crammer would have to know some medicine and surgery, but how much of a practical kind? Almost none.

Third.—There is no examination for those desiring to follow a specialty.

Taking up for discussion caption number one, viz.: "In most of the States the examination is a written one, and there is little practical about it." We find that herein lies the greatest and most palpable weakness of the State Board examinations. Medicine, as practiced, is an art as well as a science, and yet, when we come to the examination, the passing or flunking of which determines whether the graduate of a reputable school is to practice

or not, we find that the art is ignored, and even to a great extent, the science, for in that laboratory technique so necessary for the the present-day practice of medicine, the knowing and the doing are so closely interwoven that only the doing can prove the knowing. An examination on paper of an applicant's laboratory ability is but a poor makeshift for an examination. A student can study up on the blood and *on paper* tell you all that the question calls for, but given a patient and the necessary apparatus and he may make but a poor showing at a blood count, a hæmoglobin test or a differential diagnosis between the blood in simple anæmia and the other anæmias. Perhaps he can tell you all the theories about the formation of urinary casts, and yet have difficulty in telling one cast from another. Or, he can describe in detail Biedert's method of examining sputum for the tubercle bacillus, and yet can not make the examination satisfactorily with all the necessities at hand.

Again, he can describe the proper dressing for some fracture, and yet, when made to apply it, you may find that he has lost sight of the principle on which this dressing is based, and so will apply a dressing good to look upon and good for that only. He can outline the lungs, heart, spleen and other organs exactly—*on paper*—but given a patient suffering with diseases of one or more of these organs and you will find that many applicants would fail to discover exactly how the outlines had been changed by disease.

We could go on enumerating the weaknesses of the recent graduate in every branch of medicine, but that would be an unnecessary waste of time. It is about the weaknesses of the State Board that we write, for by curing these we can hope to cure those of the student. If we, however, allow them to become greater than they now are, we will find the graduate every year becoming more of a knowledge box, but much less of a practitioner. How can such a state of affairs exist when the schools throughout the country are becoming more and more practical in their curricula?

We grant that this is true, especially in the North, but would like to call your attention to the fact that many graduates of schools, which lay great stress on the practical side in teaching,

either make very poor marks, or flunk outright when they take the examinations in some States. Some of them even flunk after having had a hospital training. All this goes to show that many of the Boards have lost sight of the aim of the examinations, which aim is, first and foremost, to find out not just how much the applicant knows, but whether he knows enough to practice medicine with benefit to his patient. They fail to realize that the man who can pick up two lungs and say this one was removed after death occurring during the second stage of pneumonia, while that one is the lung of one who suffered from tuberculosis, knows far more about those diseases than the man who can describe those diseases *on paper* and yet can not tell the pathological condition when he sees it. The former has a good foundation on which he can build, the latter has already a beautiful building, but a weak one.

What chance would most of the older practitioners have against the examinations given today, provided they had no previous preparation? Who would make the better showing, the recent graduate or the old practitioner? Your answer to the second question is, the recent graduate, of course. But if the examination were practical, which would carry the honors? The older, more experienced man, of course. Now, it seems to us that the State Boards of Examiners throughout the country should try to lessen the disparity between the practical and theoretical knowledge of the recent graduate and the practical and theoretical knowledge of the older practitioner, and this can only be done by making as much of the examination practical as is possible. These examinations can be made more practical, should be made more practical, and therefore we offer some suggestions.

In the first place, instead of the examination being held in some official building, they should be held in a hospital connected with some medical school. If the school can not get access to a hospital, then that school should close its doors, for it belongs to another decade. Every branch that has a practical side should have the proper kind of practical examination as well as an oral or written part. We suggest that instead of having the examinations all

written ones, the following at least should have their laboratory or clinical side:

Physiology—Certain experiments should be done in the presence of the applicant, and he should explain the result, or state what the result should be. He should also be made to do some common experiments himself.

Anatomy—Dissections, models, pictures, etc., should be brought in, and the candidate should be made to demonstrate parts with which every graduate should be familiar. He should even be made to dissect a part, demonstrating as he dissects.

Chemistry—Tests in qualitative analysis and other chemical tests.

Materia Medica—Identification of drugs having characteristic appearances.

Pharmacy—Tests in incompatibilities, preparation of some of the commoner Pharmacopeial preparations.

Histology—Should be almost entirely microscopic.

Pathology—He should identify gross specimens of morbid anatomy, and explain the pathology, and the rest of the examination should be almost entirely practical work with the microscope and drawing.

Diagnosis—His ability to outline the organs should be demonstrated on a patient.

Medicine—He should take a case history, make a diagnosis, and prescribe the treatment.

Surgery—Not only should he take a case history, make a diagnosis and outline the treatment, but he should also be required to put on certain bandages and dress wounds. He should also be required to do thoroughly, with special regard to the technique, several operations on the cadaver.

Obstetrics—This can't be made practical in the true sense of the word, because of lack of material. However, an up-to-date manikin should be on hand, and a dead baby, preserved by some injecting fluid, should be used. The applicant can be made to make deliveries both with and without the forceps. This is only a substitute, but a good one. While in Vienna I had courses in Schauta's clinic, and work at the manikin with dead babies was very instructive, and would quickly show off how much the student knew.

Clinical Microscopy—Including Urinalysis, Blood Work, Examinations of Sputum, Gastric Contents, and Feces. This examination should be held in a properly equipped laboratory. In this examination, it seems there should be a time limit and the applicant allowed the use of books inasmuch as he will use books in such work just as soon as he commences to practice. If books were allowed in as many examinations as possible it would impress upon the student that the ability to do things accurately is more important than the ability to learn by rote, and it would also force him to learn to use books quickly and accurately. This is something many don't learn for years after graduation, inasmuch as they are slaves to their notes.

It seems to us that in the branches mentioned above, and perhaps others, the examinations can be made more practical. Of course it is not to be expected that four years in any medical school can develop the *tactus eruditus* to perfection, nor can the laboratory technique be fully developed in so short a period of time. However, a certain ability to outline organs, recognize pathological conditions, take case histories, dress wounds and make laboratory diagnoses should be a *sine qua non*, and any applicant who doesn't come up to a certain standard in these practical tests should be rejected, no matter how perfect his written examination may have been.

Let us now take up for discussion caption No. 2., viz.: "They don't raise the standard of the medical schools, inasmuch as it would not be difficult for any high school graduate to cram up for two years, perhaps even less, and pass the examination with a good mark." Under such circumstances the applicant would have to know some medicine and surgery, but how much of a practical kind? Very, very little. In order for the State Board examinations to be a force in raising the standard of medical education (and this was one of the purposes for which they were instituted), they must lay stress on the practical and leave the theoretical largely to the schools. Because of this attitude of the examiners we find that the schools have in many places become veritable cramming institutions, teaching didactically what should be taught by practical lessons, and wasting time drilling isolated

facts into the students' heads, when much of that time could have been employed in laboratory and bedside instruction. Demonstrations from patients, cadavers, models, specimens and pictures are often omitted, because the practical knowledge learned from such demonstrations will not pass an applicant without he has in addition the little isolated facts so often required on examinations. It takes time to cram in these facts, because many of them have to be crammed in again and again, since they are of such little practical value that they are forgotten from day to day. Since no school desires its students to fail in the examinations the students are often taught facts of little importance in general practice, the teacher often apologizing with the phrase, "The State Board often asks it."

This desire to make the student thorough in theoretical or rather impractical knowledge is often reflected back from the State Board into the college, and often you will find a question like this in a college examination paper, viz.: name and describe sixteen different methods of detecting sugar in the urine, or give a complete list of the amotile bacteria. Are such questions fair unless you are holding an examination for specialists? It is all very well to know these facts, but aren't there others much more important? If the time the student devoted to learning such "memory developers" were spent in percussing his roommate, putting on bandages, dissecting or operating on the cadaver, etc., wouldn't the student be much better off, both physically and mentally? And, when, after graduation, he made his first professional calls, wouldn't he be better fitted to do his duty?

Because of the questions asked by many State Boards, most schools throughout the country must teach and lay stress on points like the above-mentioned, which could be acquired—if necessary—after graduation. No matter where the college is located, it must prepare the student for all State Board examinations, because few colleges teach students from only one or two States. Students "strain" their brains trying to remember many points only until the examination is over, and are then only too glad to forget them. Why should the successful practitioner know by rote Marsh's test for arsenic, or even four, not sixteen, methods

of detecting sugar. If necessary, he can find Marsh's test in any good book of chemistry, and will naturally choose the most accurate test for sugar in doubtful cases from the existing literature. A regular chemist should make the test for arsenic anyway, since often two lives are at stake, and no chances of a mistake should be taken. It seems to us that the State Boards would ask a more practical question were the applicant asked to tell in detail just how he would act in a case of suspected poisoning.

There is little to say about caption No. 3, viz.: "There is no examination for those desiring to follow a specialty," except that it does seem there should be some special examinations for those who intend to be specialists in order to protect the bona fide specialist in surgery, obstetrics, pediatrics, etc., from others who proclaim themselves specialists without any claims to such a title, no special training and no degree to show that they are better prepared for that line of work than others. Of course it is hardly to be expected that the law require a man to pass a special examination in surgery, or other branches, before proclaiming that his specialty, but the law could require the aspirant to take an examination before he used some degree which would show he was qualified above others to specialize along certain lines. This would protect not only the bona fide specialist, but also the public, for if people employed a pseudo-specialist they would have only themselves to blame.

It is true the State Boards were not instituted with any such direct purpose in view, but they were instituted in order to raise the standard of medical education and to protect the public, and some such provision would, to a great extent, control the "fake" specialist.

There are many specialists eminently qualified in their particular branches, but there are also, as we all know, impostors, working havoc on the ignorant public. If some provision were made whereby a degree should be the distinguishing mark of the specialist, the newspaper advertising specialists would be to a great extent eliminated, because if they advertised without a degree the public would know that they were not all they claimed to be, and so would not fall into the trap set for them.

In closing, we wish to say that this is a criticism of the State Boards only in so far as they are guilty of asking questions, which, under the circumstances, could almost be called foolish. To those Boards which are guilty we make no apology; the others, we feel sure, will agree with us to a certain extent at least, and we even hope this latter group will help bring about the practical examinations in States where at present they don't exist.

Selected Articles

THE PATHOLOGY OF PREGNANCY.*

BY DR. GEORGE B. LAWRASON, Shreveport, La.

I have chosen my subject, "The Pathology of Pregnancy," because I believed it would be the most interesting and useful one I could think of bringing up before the Society for discussion.

I am well aware that the subject is too extensive for one paper, and for that reason requested members of the Society who wished to read the papers in this section to select some portion of the pathology of pregnancy, so that, as a whole, we should present to the Society a very complete discussion.

The habit of menstruation is established, as a rule, many months before pregnancy occurs, so that unusual contraction and congestion occur at what would have been the menstrual period during a pregnancy.

This enables us to calculate very accurately the date of delivery by counting ten (10) lunar months from date of the last menstruation. Now, as fecundation could have occurred at any time between this last menstruation and the first miss, evidently the delivery must be brought about by that monthly exacerbation of contraction which comes about the time the fetus is ready for expulsion. But this habit which enables us to predict delivery also warns us that, as every monthly period is due, there looms up the danger of miscarriage, greatest with the first month and lessening on succeeding months, as the uterus becomes more tolerant of its burden.

Could we be aware of it, I have no doubt that a large number of miscarriages occur at the first menstruation, and to such of my patients, anxious for children, I have recommended confinement to bed from a day or two before, to the end of what would be the menstrual period. If pregnancy is established, then the slightest pain or show is especially dangerous as each month comes around.

*Read before the Louisiana State Medical Society.

Besides rest, we combat miscarriage according to the prominence of the symptoms of pain and hemorrhage.

I will never forget once in my practice being called to see a patient about three months pregnant who had so much hemorrhage that I thought everything had passed with the clots which had been thrown away before my arrival. Considering that, the only thing to do was to stop the hemorrhage, I gave large doses of ergot, and, much to my astonishment the pregnancy continued after the hemorrhage stopped. On looking up the literature of the subject I found that some masterly articles had been written on the use of ergot in preventing abortion.

Of course, opium in some form is our sheet anchor, and I feel I have obtained very good results with some of the remedies that contain viburnum.

As to when we should use one drug and when the other, the rule is easy—ergot for hemorrhage, opium and viburnum for pain, giving prominence to one or the other drug, according to the prominence of one or the other symptom.

Next, we will take up the nausea and vomiting of pregnancy.

I can not believe any nausea at that time is ever normal, for I have seen patients go through the whole pregnancy without it. In many cases it is only a discomfort; in serious cases it becomes a tragedy.

Many patients become nauseated on rising in the morning on an empty stomach, and the mere precaution of having them stay in bed until a little while after taking their breakfast each morning will be sufficient. On others, we may try every drug we have ever heard of, either internally or locally, to the cervix, without any effect.

Some of these will suffer daily martyrdom cheerfully, upheld by a supreme desire for a child, or by religious scruples, and will run the risk of dying rather than consent to an abortion.

Others may be driven to the verge of insanity by their suffering.

The rule I follow is that where I can not relieve these symptoms, and find a patient losing ground from day to day, I lay the case plainly before husband and wife, telling them of the pos-

sibilities of going through to term safely, as well as of the dangers to be incurred, and let them make their choice.

If, however, albumen should appear in the urine, with the excessive vomiting, then unhesitatingly insist upon abortion as the only hope of the patient. It is a toxemia, and the source of the toxemia can be removed by emptying the uterus. If our patient dies it is because we have not emptied the uterus soon enough.

One case of miscarriage (I have seen a number of such cases) is where a retroverted uterus becomes impregnated. In these cases the fundus does not rise above the promontory of the sacrum and we have first symptoms of bladder irritation from pressure of cervix against the sphincter of the bladder, and, finally, as the uterus grows, the pressure becomes great enough to stop the urinary flow and enormously distend the bladder.

I remember one case, a negro woman, was admitted to the Shreveport Charity Hospital whose bladder reached nearly to the umbilicus. She was immediately catheterized and an enormous amount of urine was drawn. On examination the fundus was found in the hollow of the sacrum, and the os, which pointed toward the bladder, could not be reached by digital examination. The next evening she commenced to have pains and a bloody discharge. The catheter could no longer be introduced; it was impossible to pull the cervix down or push the fundus into the abdomen. She was put on the operating table, the bladder was opened from above, emptied, sewed up with catgut, then the peritoneum was opened, the hand was insinuated under the uterus, which was lifted out of its prison, the wound was closed and the patient made a quick recovery. Afterwards, going to term, a normal pregnancy.

But all cases are not as extreme as this one—by recognizing the condition early enough and placing the patient daily in Alexander's position, pulling the cervix down and pushing the fundus up, we can tide the patient over until the uterus has grown large enough to stay in the upper abdomen.

We now come to one of the great problems of pregnancy—the finding of albumen in the urine.

A woman needs sound kidneys to make a pregnancy safe—

perhaps nature did not intend for toxemia to go with pregnancy, but practically there is more or less toxemia in all pregnancies, and it develops upon the kidneys to excrete this noxious substance. Capricious, healthy kidneys may safeguard a patient who has a considerable amount of toxic substance. Crippled ones may get along when there is little of the toxins of pregnancy.

But the average woman stands a poor chance, if she starts child-bearing, even with a mild form of chronic nephritis. Do we not treat nephritis by lessening the work of the kidneys? Do we not restrict food and curtail exercise for fear that an acute Bright's may become chronic? How much more should we dread the overwork thrown upon them by pregnancy!

No, a woman with nephritis is too handicapped to subject herself to the perils of motherhood. But if a woman shows albumen in the urine toward the latter half of pregnancy, the question arises: Should we stop that pregnancy? Not necessarily.

Rest and diet to decrease the work of the kidneys. Purgatives to supplement that work will tide many over this perilous time.

However, should convulsions supervene, showing that proper excretion has failed, if we wish to save our patient, the uterus must be emptied at once. Our fight for her life will be none too easy, even with the advantage of having removed the source of the poison.

I will now call your attention to a very important question—When shall we use forceps in labor? I will first ask another question: Do forceps, properly used, cause injury? Remember, I say *properly used*. They should be used with thorough asepsis, also with gentleness; we should not try to pull the child through too contracted a pelvis. I think forceps applied high—that is, in the womb, as is often necessary—have a tendency to produce a greater amount of cervical tear in dilating the cervix than the bag of the waters, or even the head of the child in dry labor, so that the greater the delay, consistent with safety to mother and child, the less injury to be expected from their use. There are greater dangers, however, than cervical tears, and forceps applied high are more often called for than after the head has emerged from the cervix.

What shall be our rule? It differs with every patient. No two patients suffer the same amount of pain, no two patients bear the same amount of pain equally well, mentally or physically; therefore the necessity for instrumental interference will differ with every patient.

My first rule is that the patient who needs to be anesthetized before the head is on the perineum should be delivered with forceps. The dangers of anesthesia are, in these cases, very much greater than any injury forceps could be blamed for.

My second rule is that lack of sufficient progress proportionate to the muscular exertion of the uterus, from whatever cause, such as faulty position, small pelvis or a very large child, needs mechanical interference, and we should not wait for the patient to become exhausted before using forceps.

My third rule is that, in any condition necessitating quick delivery, *per vaginam*, it should be done with forceps.

My fourth rule is that, should we have uterine inertia after the first stage is complete, the danger from continued pressure of the head on the soft walls of the vagina is great, and the application of forceps so easy and harmless we should never hesitate to use them.

As to the placenta, give it plenty of time to come of its own accord. Keep the womb contracted by kneading it. If there is a true adherent placenta—a rare condition—then you can only be certain of removing it by the introduction of the hand in the uterus.

With a contracted, well-emptied uterus, we have no fear of hemorrhage from the placental site, and ergot and manipulation will contract the uterus. But we do have hemorrhage, often copious hemorrhage, under such conditions. Hot-water douching here is mere waste of time. A needle, catgut and needle-holder, is what we need, for such bleeding is from a torn vessel, and your patient is not safe until a suture has been introduced so as to close it.

This brings us to the subject of laceration. When should we mend a laceration? I will not weary you with the arguments of waiting five to seven days after delivery. I was once thoroughly

convinced that it was the right thing to do, and that I had in the past been very wrong in attempting immediate repairs. Gentlemen, my advice to you is to do the best you can at once; your patient won't stand for the other. They want a rest after what they have gone through, and not another operation.

And now a few words about dry labor and I am through. Suppose you have a patient who is dribbling the amniotic fluid during the last month of pregnancy; what are you to do? As far as I know, nothing, except to keep your patient as quiet as possible and await developments. No trouble may come of it, for you may have on your hands a practically normal labor. On the other hand, try to make ready for the worst, as you may have to confront the necessity of Cæsarian section. I have had experience both ways.—*New Orleans Medical and Surgical Journal.*

Extracts from Home and Foreign Journals.

SURGICAL

CHRONIC APPENDICITIS.

After a critical study of the post-operative end results in one hundred cases, and a review of the literature the writer arrives at the following conclusions:

(1) The majority of patients suffering from chronic appendicitis give a history of having had one or more attacks of abdominal illness, with a sequence of symptoms recognizable as those of an acute appendix attack, viz., sudden severe abdominal pain, usually beginning in the epigastrium or mid-abdomen, accompanied by nausea and vomiting and followed by a period of pain and tenderness in the right lower quadrant.

(2) "Appendiceal dyspepsia" has been characterized by symptoms strikingly analogous to the earliest symptoms of acute appendicitis, viz., attacks of epigastric or mid-abdominal pain, or distress, only rarely accompanied by subjective symptoms referable to the region of the appendix. During these attacks the pain or distress is nearly always increased by food intake.

(3) Pain confined chiefly to the right lower quadrant and not associated with attacks of epigastric pain and nausea is seldom due to the appendix, and before making a diagnosis of chronic appendicitis in these cases every other possible condition should be excluded.

(4) The majority of failures have been in patients complaining of right inguinal pain associated with chronic constipation. At operation these patients have presented an unusually long or dilated cecum, usually accompanied by other evidences of enteroptosis. In the future a certain proportion of these patients may be cured by some such operation as that advocated by Wilms, but appendectomy alone does not cure.

(5) Unless the diagnosis is absolutely certain, the gall-bladder, stomach, and right kidney should be explored, and the possibility of a Lane's kink excluded in all cases operated upon for chronic appendicitis.—*American Medicine.*

PITUITARY EXTRACT AFTER ABDOMINAL OPERATIONS.

The author employed this drug in twenty-one unselected laparotomy cases. In two cases the dose given was $\frac{1}{2}$ c.c. (8 minims), commenced twelve hours after the operation and given every four hours for three days. In the other cases the dose was increased to 1 c.c. (16 minims) for adults. It was commenced about six hours after operation and repeated every four hours until eighteen doses had been given.

From the result of the injections the author considers it evident that pituitary extract has a very marked effect upon the muscular coats of the bowel, and that it is able to overcome the temporary paralysis due to their exposure at the time of operation. This is shown by the early passage of flatus and absence of abdominal discomfort. In only three cases did the bowels act without the assistance of an enema, but in every case except two a satisfactory action of the bowels was obtained after a simple enema, and it was unnecessary to give any aperient by the mouth. All the patients passed flatus freely within a few hours of the first injection, and were free from any abdominal pain or distention. The pulse rate remained much lower than usual, and after some of the most severest operations it did not exceed eighty per minute. Except in the last two cases, no patient suffered from post-operative retention of urine, and so catheterization was unnecessary.

The patients treated with injections of pituitary extract after operations are more generally comfortable, the author states, than those who do not receive them. He does not consider, however, that the drug can be relied on completely to empty the bowels without the assistance of enemata, and, therefore, does not think it need be employed after the first twenty-four hours. He recommends three injections of 1 c.c. each during the first twenty-four hours as a routine practice after laparotomy. They must be made into a muscle, subcutaneous injections causing pain. The first should be given six hours after operation, and the other two at six-hour intervals. No further injections need be given unless there is distention. Suppuration at the site of injection (into

the biceps) was the only unpleasant symptom the author witnessed. No general symptoms were ever produced.—*Monthly Cyclopedia and Medical Bulletin*.

SUCCESSFUL LIGATION OF THE PULMONARY VEIN OF THE LEFT LOWER LOBE FOR SHOT WOUND.

Heile reports the second case of this type, the first having occurred in von Eiselsberg's practice several years ago. The natural termination of these cases is death, rapidly ensuing. The patient was a boy who attempted suicide with a revolver discharged toward his heart. The first diagnosis was wound of the heart. The third and fourth ribs were immediately resected and the seat of the injury revealed. Suture seemed out of the question, because of the inaccessibility of the lesion. In von Eiselsberg's case, however, it had been possible to close the wound directly. This author first succeeded in clamping the bleeding vessel, after which he placed upon it a double ligature. Aside from the threatening heart failure, the chest symptoms were out of all proportion to the severity of the case, being almost absent.—*Medical Record*.

CATGUT STERILIZATION.

Hutchings, in the *Annals of Surgery*, places raw catgut, without any previous treatment, in suitable tubes, which are left open, and put in an ordinary vacuum desiccator over sulphuric acid. The air is withdrawn from the desiccator until a pressure of less than four minims is secured. The connection between the desiccator and the pump is then closed, the pump removed, and the desiccator set aside for eight days. At the end of this period, air, dried if necessary by passing through a Wolff bottle containing sulphuric acid, is allowed to enter the desiccator. The tubes are removed and sealed, and are ready for sterilization. Any method of heating may be employed, but the author in his work used a mixture of glycerin and distilled water with a boiling point of 150° c., the container being fitted with a reflex condenser. The

sealed tubes are placed in the container and boiled for two hours. Experiments made with catgut impregnated with various bacilli showed that after this method of sterilization none of the catgut was contaminated. Control animals inoculated with the gut before sterilization died of the diseases.—*The Medical Brief*.

CORRECTION OF NASAL DEFORMITIES BY MECHANICAL MEANS AND
BY THE TRANSPLANTATION OF BONE.

William Wesley Carter, New York (*Medical Record*, December 9, 1911), describes two methods which he has devised for the relief of deformities of the nose and of the nasal septum. He divides nasal deformities into those with and those without loss of bony tissue. In the former he employs the "bridge" splint, a hinged framework adapted to keep the tissues in place with the aid of internal molded rubber splints. These can be used wherever there is sufficient bony tissue to support the splints. The author has operated upon fifty patients by this method, including recent fractures, old, depressed, and irregular fractures, and lateral deformities. Great care should be used in the selection of cases. The bony framework should be thoroughly mobilized, and, if necessary, the septum lengthened; the wings of the bridge must be well padded with gauze and the skin on which they rest should be bathed with alcohol to prevent excoriation. In nasal deformities attended with loss of bone the author employs an autoplasmic operation, transferring bone from the ninth rib of the patient to take the place of the bone that has been lost. He does not remove the periosteum with the bone, since he does not wish to produce new bone. This method is of great value in cured cases of syphilis in which nasal deformities are present. The introduction of the bone never causes any irritation and the wound quickly heals.—*The American Practitioner and News*.

BLUE LIGHT AS AN ANAESTHETIC.

More than thirty years ago there prevailed what was afterwards termed the blue-grass craze. All sorts of ailments were

thought to be amenable to the action of blue light, and the newspapers were filled with glowing accounts of cures. Enthusiasm ran riot for a time, and then the matter dropped out of sight. Quite some time later there was a revival of interest in phototherapy when Finsen demonstrated the curative properties of the ultra-violet ray in various affections, especially lupus. Since then the physiological action of light has been carefully investigated, and although much remains to be learned, there can be no doubt that we are nearer to an appreciation of its possibilities in the treatment of disease.

One of the most remarkable actions of light has recently come to our attention. In an address before the Boston Physio-Therapeutic Society Dr. E. C. Titus demonstrated that blue light possessed remarkable anesthetic power. In his experiments he used a series of slender glass rods about one-eighth of an inch in thickness, placed side by side and tied together so as to form a kind of flexible mat which will adapt itself to various parts of the body. The glass must be of cobalt blue and transmit no red rays, this being a very important point. The rods are to be placed upon the area to be anesthetized, and some form of white light, preferable a tungsten lamp, brought as closely as possible without causing discomfort. Strange to relate, in twenty minutes the part becomes insensitive, so that superficial and even deep incisions or punctures are no longer felt. This anesthesia lasts for one-half hour or more, and has occurred so constantly that there is no reason to believe that it is the result of suggestion or accident. Minor surgical operations have been performed under this method and without the least pain or discomfort, and there seems to be enough in it to merit attention.—*International Journal of Surgery*.

HOW LONG SHALL PATIENTS BE KEPT IN BED AFTER OPERATION?

Miller regards it as being probable that enthusiasm for early rising after operation has warped better judgment. Too little has been said in defense of conservatism along these lines. It

does not seem rational to him to demand added effort of an already heavily burdened patient. He emphasizes that when we ourselves are tired, we rest; when medical patients evidence fatigue, we insist on rest and quiet. In the treatment of exhaustion, injury or febrile conditions, we enforce, first of all, the rule of rest; we are therein frankly recognizing a law of nature. We can not make so critical a group of post-operative cases exempt from this law without incurring great risk. Rest is an essential element in post-operative care. The duration of its enforcement must be decided for each case as an individual, and not as a representative of this or that group, and in this decision there is frequently need for nice judgment. We can not reduce it to a rule of thumb.—*Journal of the American Medical Association.*

OBSTETRICAL

PUERPERAL INFECTION.

The number of cases treated by Watkins in the last two years has been seventeen. The treatment consisted chiefly in the use of measures to increase the body resistance and thus hasten "immunity." The remedies employed have been much the same as used in cases of tuberculosis to increase the physiologic resistance. The treatment consisted chiefly in: 1. Raising the head of the bed to promote drainage. 2. Putting an ice-bag on the abdomen. 3. Giving a large amount of nutritious, easily digested food. 4. Administering at least two quarts of fluids daily and otherwise forcing elimination. 5. Keeping the patients out of doors a part of each day when possible and giving sunbaths. 6. Seeing that pain was relieved and that six to eight hours of sleep was obtained daily. The uterus was not disturbed except for hemorrhage or when a retained fetus, placenta, or decidua was known to be present. When present they were removed without the use of an anesthetic and without producing much traumatism. When the cervix was not well dilated the uterus, cervix and vagina were packed with sterile gauze to promote dilatation,

to cause separation of the placenta or decidua, and to stimulate spontaneous expulsion.—*Journ. of the American Med. Assn.*

MEANS FOR ARTIFICIALLY INDUCING RESPIRATION IN INFANTS AND YOUNG CHILDREN.

Ssokolow places the child on a table with the head hanging down over the edge. Then he lifts up the head, bending it down on the sternum, at the same time as he draws up the legs until the knees touch the region of the sternum. Repeating these movements rhythmically he has been able thus to recuscitate apparently asphyxiated infants and children with never a failure. He explains the mechanical principle involved as that the traction on the chest muscles pulls on the sternum and scapulæ as the head drops backward. This is the phase of inspiration, while expiration is induced as the head is doubled forward on the chest and the abdomen squeezed by the child's knees. Other important factors are the traction on the tongue and larynx and the flux and reflux of blood into the brain, acting on the respiration center both directly and by reflex action. He has found the method particularly useful in asphyxia during or after a tracheotomy operation. Two illustrations show the technic further. He adds that it is harmless for the child. There is no need for letting the child get chilled while it is being applied. It is not fatiguing for the physician, while it has the advantage over the Schultze method of the reflex action from traction on the tongue and larynx. Another advantage is that the head does not have to be held in the hand all the time.—*The Journal of the American Medical Assn.*

TOTAL HYSTERECTOMY IN TUBERCULOUS PREGNANT WOMEN.

It is generally admitted that if a tuberculous pregnant woman becomes rapidly worse in the early months of pregnancy, the latter should be terminated. The usual method is the artificial induction of abortion, but after the second month or thereabout the unfavorable result of the often copious and protracted hem-

orrhage must be borne in mind; and despite the care enjoined upon the husband in reference to the prevention of a further pregnancy such a contingency is very likely to happen. Hoehne, at a recent meeting of the Medical Society of Kiel (*Münchener medizinische Wochenschrift*, October 24) commended the practice under these circumstances of total vaginal hysterectomy, including ablation of the adnexa. The idea was first carried out by Bumm upon a series of women now aggregating twenty-six. The author has thus far operated three times, but in one case he performed a supravaginal abdominal hysterectomy, leaving the adnexa intact. Hemorrhage was less than in the average abortion. Further, as general narcosis is not always justifiable in pulmonary tuberculosis, the author preferred lumbar anesthesia. Again, in these cases removal of the ovaries so far from being harmful was believed to exert a favorable influence in tuberculosis. In any case, the latter disease showed quite a notable improvement as the joint result of interrupted gestation and castration.—*Medical Record*.

ECLAMPSIA, THE BLOOD PRESSURE INDEX OF.

Triweekly blood pressure examinations, combined with the regular urine examinations for albumin and casts, offer the best safeguard, according to the studies of the author, against the unexpected occurrence of this affection. The average blood pressure in the last weeks of pregnancy is 118 mm. Fluctuations amounting to 30 mm. Hg above this need cause no alarm. Blood pressure over 150, however, should be thoroughly investigated at once.

The blood pressure in eclampsia with convulsions, though usually in the neighborhood of 200 mm. Hg, may be as low as 155 mm. Convulsions do not occur when the blood pressure is lowered by poor resistance, as in the so-called fulminant cases, or when lowered by veratrum viride or other drugs producing collapse. Treatment should be directed not toward reducing the blood pressure, but to removal of the toxemia, for the rise of

blood pressure may denote only the resistance of the system toward the toxins.—*Monthly Cyclopedic and Medical Bulletin.*

OZONE AND FERTILITY.

R. L. Hammond, Woodsboro, Md., says that ozone was formerly held in high esteem, and is, no doubt, a potent agent, exerting a triune meteorological effect in the prevention, causation and cure of many diseases, particularly the epidemic and miasmatic varieties. Its history reveals many interesting opinions regarding its value in the animal economy. In "The Year Book of Treatment," 1892, p. 347, Lea Brothers & Co., I find the following, which will show the value placed upon it by some apparently competent observers: "Dr. Samuel S. Wallian (*New York Medical Journal*, 1891, vol ii, p. 101), makes some statements which, if correct, are important. He says that at Trincomalee, in Ceylon, from May to September, the southwest monsoon blows over the island, and in passing through the jungles gets robbed of its ozone. From October to April the northwest monsoon blows over the Bay of Bengal, and arrives at the village laden with ozone. From May to September the ozone was 2.5, and the number of conceptions 57; from October to April the ozone was 8, the number of conceptions 100. The Malagash negroes breathe a scantily ozonized air, and are noted for their want of fecundity; while on the east coast of Central America, and on the north side of Cuba and Jamaica, where the atmosphere is nearly always highly ozonized, large families and multiple births are quite the rule. He thinks there is no doubt that the free use of active oxygen has a marked influence over the procreative function. Patients who have regularly inhaled the artificially-prepared gas for some weeks or months, for various ailments, have almost invariably found themselves gradually recovering lost sexual tone to a decided degree. Numerous observers have corroborated each other on this point, and in nearly every instance the results noted have been wholly unanticipated. Cases of sterility have, under its use, recovered, and impotence of long standing has given place to a fair degree of virility. A physician of Dr. Wal-

lian's acquaintance, who has made extensive use of active oxygen in his practice, declares that he has but one objection to its use, which is, that it invariably arouses the sexual appetites of those patients who persist in its use for any considerable time."—*Virginia Medical Semi-Monthly*.

REPEATED CESARIAN SECTION ON THE SAME PATIENT.

Mrs. E. S., aged 27, married four years, presented herself at the Methodist Episcopal Hospital three years ago, after being in labor 55 hours. She was a primipara with a just minor pelvis, into which the head refused to enter. Attempts at engagement were made under anesthesia, and tentative traction made with the forceps, which made the disproportion between the head and the pelvis apparent. A Cesarean was done and a 10¼ lb. child delivered. The recovery was uneventful.

Fourteen months later she again appeared in the same service at term. On abdominal examination, the child was found to be large. Previous experience guided us in deciding to deliver her by an elective Cesarean section, from which she recovered without complication, except for a fistulous tract running from the upper angle of the second wound into the structure of the abdominal wall, for a distance of two inches. Repeated carbolic acid treatment of this tract failed to close it.

In March of this year she again returned in Dr. Polak's service, pregnant, and at full term, and a third Cesarean was done upon her by Dr. Holden, through a median incision, which included the umbilicus. The omentum, which was found adherent to the previous scars, had to be pushed aside in order that a uterine incision could be made in the fundus. With the consent of the patient and her husband, the tubes were excised at their uterine ends and sewn by their peritoneal envelop to the posterior surface of the uterus, after the method of Harris. The interesting point of this case was the condition of the former scars in the uterus, which were carefully examined and found to be firm and thick.—*Long Island Medical Journal*.

SEX DETERMINATION.

The subject of Sex Determination is in no way receiving less attention of the profession than its mother subject the gynæcology. Books after books have been written and not a day passes when we come across a new method of determining the sex. Some believe that the parental influence has much to do with the sex of the unborn, others explain their experiences of determining sex due to coitus after or before the menstrual period, and others say that the right and left ovaries determine the sex of the expected child. In short every one has his different theory based on his experiences of a small or great number of cases. Here is another theory advanced by Dr. Calhoun mentioned in his book Sex Determination and Its Practical Application, published by the Eugenica Publishing Company of New York. The theory itself is not a new one, but the practical side of it is interesting, and we shall be glad to know as to how it strikes our readers and how far they think it is practical.

The laws, as described by the author, are based on the theory that the left ovary of woman produces female offspring while the right ovary produces male offspring, and the gravitation determines to which side the spermatozoa go. If the mother wishes for a girl and continues persistently to remain on her left side for a few hours after the introduction of the fertilizing spermatozoa in the uterus and specially refraining from lying on her right side for at least twelve hours, then if she is normal she will give birth to a girl baby. If she wishes for a boy and continues persistently to remain on her right side for a few hours, but specially not lying on her left side for at least 12 hours after the introduction of the fertilizing spermatozoa in the uterus, if she is normal and carefully follows these directions she will give birth to a boy baby.—*Practical Medicine*.

APPENDICULAR ABSCESS FOLLOWED BY PHLEBITIS OF EXTERNAL JUGULAR VEIN.

Not finding the appendix easily, and being unwilling to break

up the adhesions about the cecum, Richards did not remove the appendix, but drained the abscess through the wound, sewing up the remainder of the incision. The drainage was free, and on the third day following the operation the temperature was normal, and the bowels had moved well. No untoward symptoms developed until the eighth day, when the temperature rose to 105 and the pulse to 140. There was also a chill. The drainage was free and there was no signs of extending peritonitis. The drainage had a fecal odor, but not more so than at the time of the operation, and there was no more fecal matter in the drainage. The patient complained of a stiff neck, with soreness in the left side of the neck. On the following day the pain in the neck was much more severe, so Richards examined this region more closely and found the external jugular hard like a cord, and very painful to the touch. Just above the clavicle there was some perivascular inflammation. Richards immobilized the head, and gradually the inflammation disappeared.—*The Journal of the American Medical Association*.

HYSTERIA AND MALINGERING.

In a brief exposition of what he calls the phylogenetic or evolutionary conception of hysteria, as being due to an exaggeration (or disorder) of tertiary (nervous) female sex characters, Weber endeavors to explain why hysteria (according to his conception of hysteria) is so frequently associated with a tendency to simulate disease, accident or injury, or deceive in some kind of way in the absence of any adequate (rational) motives. He claims that the so-called tertiary (nervous) female sex characters, though naturally best marked and most striking in the female sex, are not the exclusive property of the female sex. They occur likewise in the male, but are usually less conspicuous in the male sex, and it is only their occasional exaggeration (or disorder) that Weber explains the occurrence of hysterical and irrational (apparently motiveless) deception and simulation "hysterical malingering") in males. Teleology (that is to say, the modern Darwinic or evolutionary idea of teleology) finds a place in the phylogenetic aspect

of hysteria and it seems to Weber also to claim a place in regard to other conceptions (Babinski, Freud, Janet and others) of hysteria. For instance, he asks, is it not conceivable that hysterical excessive suggestability may, on the whole, be useful rather than harmful for persons whose own will-power is pathologically deficient? Moreover, in cases in which wretched experiences have made their physical marks or "physical traumata" in the past and in which the present condition is in some way gravely affected by subconscious reminiscences, "separation of consciousness" may be supposed to bring not only inconveniences and dangers, but also a certain kind of relief.

Some functional nervous symptoms usually classed as hysterical are not readily explained by Weber's conception of hysteria. So-called "hysterical vomiting" seems to be a pathologically exaggerated action of the reflex defensive mechanism by which poisonous or irritating ingesta are normally rejected. But it may sometimes be on the borderland between hysteria and voluntary action simulating disease. Furthermore, Weber continues, in regard to the greater frequency of simulated diseases, self-inflicted skin lesions, etc., in women than in men it may be remembered that when a woman is depressed and altogether discontented with the life she has to lead, she is more likely than a man would be to try to attract attention or pity by simulating disease or injury. A man usually has much more open to him; he can seek a new country or (if he does not endeavor to obtain relief by drink or gambling) he can take part in dangerous ventures of various kinds which bring excitement and temporary relief.—*The Journal of the American Medical Association*.

TOXEMIAS OF PREGNANCY.

S. H. Blodgett, Boston, Mass., speaks of two types of toxemia in pregnancy; the one of uremic nature and the other indicating imperfect pancreatic action. Uremic poisoning may develop slowly or rapidly. In slow poisoning there is greater danger to the child; in rapid poisoning there is greater danger to the mother. If nitrogenous food is not decreased in slow poisoning the ex-

cretion of urea gradually decreases. One should therefore limit the amount of nitrogenous food. If these cases are recognized early enough one need not order a strictly milk diet, but a large amount of liquid should be given. The amount of physical exercise should be limited, as exercise will often precipitate an attack of convulsions. The fetal heart beats should be watched carefully and if they weaken labor should be induced. In the rapid form of toxemia headaches, pains along the nerves and in the epigastrium, and loss of appetite come on suddenly, with scanty urine of high specific gravity. Labor should be induced at once. Pancreatic toxemia is characterized by nausea and vomiting, with diacetic acid and acetone in the urine. There is soreness on deep pressure over the head of the pancreas. The treatment is bicarbonate of soda given in daily doses of from 20 to 60 grains, with hot or cold water. *Medical Record.*

MEDICAL

-- THE TUBERCULIN REACTIONS AS DIAGNOSTIC AIDS.

O. H. Benker, St. Louis (*Interstate Medical Journal*, December), has attempted to diagnose early or suspected cases of tuberculosis by noting the reaction to intradermal injections of tuberculin. His technique is as follows: The place of inoculation over the biceps muscle is cleaned with alcohol; then with a sterile platinum needle and glass syringe, the eye of the needle pointing upwards, inject 1-10 c.cm. of the following five solutions: Phenol $\frac{1}{2}$ of 1 per cent, O. T. (Koch) 1-10,000 mgrm., O. T. 1-1,000 mgrm., O. T. 1-100 mgrm., O. T. 1-10 mgrm., at a distance of 5 cm. from each other, allowing the solutions slowly to infiltrate the skin, producing a small papule. A positive reaction takes place as a rule several hours after the inoculation to 1-10 mgrm. and 1-100 mgrm., and often also to 1-1,000 mgrm., and even to 1-10,000 mgrm., showing greater intensity to the stronger solutions. After twelve to twenty-four hours the infiltration becomes visible and palpable and the inflammatory reaction increases accordingly. At the end of forty-eight hours it has reached its greatest intensity. There may then be seen a small central tuber-

cle encircled with a zone of redness, shading off gradually into the healthy tissues. The reaction fades away, as a rule, after two days, but persists at times for several weeks. The control injection of $\frac{1}{2}$ per cent phenol shows a slight erythema which becomes imperceptible after a few hours. A slight fever reaction is due to faulty technique in injecting some of the tuberculin subcutaneously instead of intradermally. The author, as the result of his experience with the method, draws the following conclusions: 1. That by the intradermal test, in doses from 1-10,000 to 1-100 mgrm., nearly all doubtful and early cases of tuberculosis can be demonstrated. 2. If, after a 1-10 mgrm, injection no reaction occurs, tuberculosis may be excluded. 3. From reaction to doses between 1-10 and 1-100 mgrm. the presence of a latent tuberculosis may be inferred.—*Interstate Medical Journal*.

THE ADEQUATE TREATMENT OF GONORRHEA.

Thomas Wright Jackson, Fort Hunt, Va., states that the army and navy surgeon has a rare opportunity to observe the treatment of gonorrhea since on shore or at sea he has under his treatment a large number of men. As a result of his experience the author believes that there is no method of treating gonorrhea in a short time. A small percentage of cases are practically incurable; a much larger proportion of cases remain uncured because the patients will not submit to proper treatment. The total number of indefinitely infectious cases is very large. There is no proper test of cure except the microscopic examination. The complement-fixation test enables one to diagnose a number of cases that otherwise might escape detection. Persistence in whatever treatment is selected is the cardinal point in the successful management of these cases.—*Medical Record*, December 23, 1911.

INDUSTRIAL DISEASES DUE TO METALLIC POISONS AND THE MEASURES NEEDED FOR THEIR PREVENTION.

M. Allen Starr, New York, cites the large number of trades in which lead is used and shows that among employees of these

trades, lead poisoning manifesting itself all the way from lead colic to tremor and palsy, is very frequent. Chronic poisoning with lead also occurs from ingestion of small amounts, with a general state of malnutrition, pallor, anemia, and lack of physical and mental capacity. Neurasthenia, headache, and loss of sight from neuritis also occur in these cases. There are some 150 trades in which this form of poisoning is found, and it occurs in large numbers of persons. Arsenic poisoning occurs in 27 trades, the symptoms being insidious, and similar to those of lead poisoning in the chronic form. Mercury poisoning occurs in the manufacture of thermometers, barometers, incandescent lamps, etc. Phosphorous poisoning occurs in the manufacture of matches. The poisoning in all these forms is due to the inhalation of dust-laden air containing the poison, or of fumes when the metal becomes volatilized. The preventive precautions are very simple, yet they have not been put into use in this country. In England good laws have been enacted and enforced, with the result that industrial poisoning has been much reduced. The precautions are good ventilation, ample washing conveniences, the use of respirators when at work, and care not to eat without washing the hands. These are all easily possible of observance. One should start a campaign of education of employes and employers, and should secure legislation compelling precautions in factories.—*Medical Record*, February 3, 1912.

THE DOCTOR'S DUAL PERSONALITY.

From a lay standpoint the doctor is a very inconsistent person, doing a great number of things which are entirely contrary to the fine line of precepts handed down to his patients. Just why it is that in his personal habits the doctor is so prone to disregard the excellent advice he gives his patients is from the layman's standpoint considerably more than a puzzle—it is a joke. It might be well for the medical profession in general if the laity understood a little better the underlying reasons for such apparent inconsistency, but the really genuine doctor never talks about himself, and especially his health, if he can possibly avoid it.

No one understands as the doctor does the results of morbid introspection. Wherever he goes, and as long as he practices his profession, the doctor is continually encountering the individual who would be in pretty good health if he or she thought so. So he would be, indeed, very obtuse if he didn't gather from these tiresome exhibitions constantly coming to his notice a valuable lesson for himself. He systematically ignores his own symptoms, unless they become a menace, in which case he promptly consults a colleague for the judicial counsel which no really ill person can provide for himself.—*Medical Review of Reviews.*

USE COMMON SENSE IN INFANT FEEDING.

During the last few years there has been a marked tendency by the medical profession to discard complicated formularies in infant feeding. This is indeed a welcome relief, as most of us have not forgotten our unnecessary expenditure of energy in acquiring this or that system of feeding. Americans have always been noted as faddists, and fall head over heels in adopting chimerical propositions set forth by leading lights without awaiting a thorough testing of new hypotheses. This characteristic had led them into many errors, in many instances to their sorrow. We have had somewhat the same experience in artificial feeding in babyhood. The modification of milk was carried to such limits that if it were not for the tragedy attached it would be laughable. In some instances the proteids, fats, etc., were so diluted that children were undoubtedly starved to death. All of us have no doubt seen children who were on the verge of death from inanition on modified diet as heretofore and even at present practiced immediately pick up and take on new life when a common-sense doctor order a discontinued fanciful modification and placed him on whole milk diluted one, two, three, etc., times, according to the indications of the case. As a matter of fact, we have been informed that teachers of pediatrics have almost entirely discontinued teaching their students systems for modification of this article of diet, and now impress upon the student the necessity of resorting to common sense in infant feeding. They have come

to realize that one child of a given age will thrive on whole milk, while another will need it decidedly diluted. There are no fixed rules, therefore, and each case must be studied individually. It has been found that the best procedure is to start the baby on whole milk diluted about four times and note how it thrives. If he manages such a dilution, but does not gain properly, then a larger feeding or a less dilute diet is ordered. We do not desire to convey the impression that scientific feeding has been without value, but that it has been carried in the past to ridiculous extremes. Undoubtedly, instances will still arise in which it can be employed satisfactorily, but the ordinary run of physicians will derive more satisfaction from the simple line of procedure outlined above.—*Maryland Medical Journal*.

A METHOD OF CURING CORNS.

In the method to be described, says the *Medical Summary*, the writer depends upon the macerating power of ordinary adhesive plaster to effect the result sought. A strip of this material from three-eighths to one-half of an inch in width and four to six inches long is to be applied in spiral fashion to the affected toe, covering the digit from neck to nail. The degree of tightness of the application deserves consideration to avoid compression. However, the feelings of the patient when stepping upon the foot will serve as an adequate guide in this matter. Given instructions to cut through the plaster lengthwise or to soak off the entire dressing by immersion in hot water foot bath afford ample protection in cases of undetected microbic infection. Soaking the foot from ten to twenty minutes in water at a temperature of 100 degrees with gentle removal of the crown of hardened epidermis, by rubbing with a piece of sterilized pumice stone or with forceps, shortens the time of treatment. Properly applied the plaster strap dressing described should afford relief from the moment of its application and may be worn continuously for from one to six or eight weeks—bathing seeming to unaffected the adhesive properties of the plaster after having once set. Removal of the dressing at the end of an adequate time reveals the corns completely

freed, when it may be picked out entirely by means of a dressing forceps or after an additional soaking. A wisp of absorbent cotton held on by means of a narrow adhesive strip may be subsequently worn for a few days.—*American Medicine*.

HEART STRAIN.

Heart strain in the aged has lately become of considerable importance, although it is an old subject in the medical world. The Surgeon General of the Army in his last annual report has called attention to the damage done to old hearts by endurance tests, and taken in conjunction with the sudden deaths alleged to have been due to the tests, this report leaves no doubt that the human frame can not possibly endure such strains after it begins the downward course after 45 or 40 years of age. Even 35 years, weakens some of the tissues so that they are dangerously strained by pressures harmless to the boy of 15 or 20. Hard daily training to keep in "condition" for muscular feats is therefore to be condemned after 35 or 40, but the exercise must be gradually lessened to keep below the danger line of tissues which are weakening as nature intended them to. Endurance lessens and we can not keep it. Our efforts only lessen it. The strenuous life after 40 is unnatural and dangerous, and after 60 is out of the question, except for a very few exceptional men who ought to be in better business anyhow.—*American Medicine*.

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at \$1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

HE WAS FIRST TO SWAT FLIES.

Dr. A. B. Tadlock, who says he was the first to declare war against the house fly, is residing at the Columbian Hotel in Kansas City.

In the widespread cholera epidemic in 1873 in the United States, Doctor Tadlock, a practicing physician in Knoxville, Tenn., was called to Greenville to aid in fighting the cholera. He noticed that in localities most thickly infested with flies cholera cases were most numerous. After a time the flies died by thousands and disappeared, whereupon the cholera ceased.

Doctor Tadlock gathered up dead flies and examined them under a microscope. The President appointed a committee to report on the cholera epidemic. Doctor Tadlock accused the house-fly of being largely responsible for the spread of the disease. Dr. Ely McClellan, U. S. A., chairman of the committee, called particular attention to Doctor Tadlock's theory, saying that he considered the idea plausible.—*Kansas City Times*.

Dr. A. B. Tadlock, so conspicuously mentioned in the above extract is known as one of the oldest physicians of Tennessee. He was born in Greene County, Tennessee, in 1836. Besides being known as a frequent contributor to our Medical Journal, and others, Dr. Tadlock was, in 1884, elected President of the Tennessee State Medical Society. He retired from the active practice of medicine about a quarter of a century ago, not so much

because of his age as by reason of blindness, the assigned cause being exposure and other effects as surgeon in the Civil War.

His discovery, above mentioned, has not only been accepted by the profession as a "plausible idea," but an established fact, and one of the most valuable factors in sanitation and the practice of medicine. The application of window and door screens and other devices instituted to fight the pestiferous housefly has become world-wide, amounting to great industrial importance. The effect, also, with the aid of the microscope, has been to implicate other insects (especially the mosquitos), in the nefarious work of scattering disease germs, notably typhoid, malaria and yellow fever, etc. As a result, yellow fever has been classed among the infectious instead of contagious diseases, and this is of great consideration and importance, commercial as well as medical.

To sum it up, the housefly has been in many places almost totally driven out and destroyed, with, as a consequence, sickness and death rates greatly diminished, noticeable recently in "summer complaint" of children. In a Kansas town, where the cold weather had killed the flies, there was immediate cessation of the disease.

A LIBERAL PROPOSITION.

With this issue of the Journal we are sending sample copies to a long list of physicians in this State whom we are desirous of securing as new subscribers to one of the oldest and best independent medical journal published in the South—the *Nashville Journal of Medicine and Surgery*. In order to interest the profession and to secure the coöperation of physicians in building up our circulation into the thousands, we propose to present to every new subscriber of the Journal, an accurate clinical thermometer, tested and certified, self registering and with magnifying scale, in twisted aluminum case, chain and pin attached, for the subscription price of the Journal—\$1.00—sent by check, registered letter or postoffice order. The retail price of the thermometer and case is \$1.50, so that the new subscriber

gets for \$1.00, subscription to the Journal for one year, beginning from the date of subscription, together with a handsome, reliable, clinical thermometer.

That our old friends, subscribers somewhat in arrears with their subscriptions, may not deem themselves slighted in this generous proposition, we make to them this proposition: To any subscriber, who, within the next sixty days from date of the issue of this Journal, sends in the amount of past due subscriptions, as per statements sent them with the beginning of this volume, we will send the thermometer, and receipt them for one year's subscription to the Journal from date of payment. We invite your attention to this proposition and hope you will, without delay, accept the offer and send in the money with your address. We want the support of every Southern physician as readers and contributors to the NASHVILLE JOURNAL OF MEDICINE AND SURGERY, one of the few remaining independent medical journals that is not bolstered up by the forced subscriptions of medical associations.

The New York State Civil Service Commission announces an examination to be held on February 24, 1912, for the position of Junior Physician (Homeopathic or Regular) in the New York State Hospitals for the insane, at a salary of \$900 and maintenance, increasing \$100 each year to a maximum of \$1,200 and maintenance, beyond which point advancement is made upon promotion examinations. As the Commission has experienced difficulty in securing a sufficient number of eligibles from among residents of New York State, it has been decided to admit residents of other States, and in order to secure added competition, the Commission is endeavoring to make arrangements for holding this examination in Boston, Philadelphia, Washington, Cincinnati, Chicago, St. Louis and St. Paul.

The New York State Hospital service comprises fifteen State Hospitals, the Psychiatric Institute, and two hospitals for the criminal insane under the Superintendent of Prisons. Over 30,000 patients are treated annually, and the service presents the best available opportunity for the study of insanity. The insti-

tutions are organized along hospital lines, with training schools for nurses, and hospital equipment including laboratories, examination and treatment rooms and surgical operating rooms. There are nearly 200 salaried medical positions in the State Hospital service, and comfortable quarters, board and laundry are provided for all appointees and for the families of superintendents and first assistant physicians, in addition to the stated salaries. To those who take up the work as a career and apply themselves earnestly, promotion is certain and as rapid as is consistent with the period required for good training and maturity of judgment. The salaries of the higher positions are as follows: Assistant Physician, \$1,200 to \$1,500; Second Assistant, \$1,500 to \$2,000; First Assistant, \$2,000 to \$2,500; Superintendent, \$3,500 to \$4,500.

Anyone interested in this examination should write at once to the "New York State Civil Service Commission," Albany, N. Y., for application blank and full information.

N. B.—The New York State Civil Service Commission desires to give above notice as wide publicity as possible and requests that it be posted in medical colleges, etc., and especially that newspapers will publish the notice as an item of news.

JOHN C. BIRDSEYE, *Secretary*

Albany, N. Y., January 25, 1912.

New York, N. Y., February 9, 1912.—Dr. Charles S. Briggs, Editor Nashville Journal of Medicine and Surgery, Nashville, Tenn. Dear Sir: Your readers will be interested to know that Prof. Dr. Carl von Noorden, of Vienna, has accepted the invitation of the New York Post-Graduate Medical School and Hospital for a series of lectures on problems of Metabolism for October, 1912.

Very truly yours,

L. KAST.

THE OVERLYING OF INFANTS.

We do not see much of this in America, but in England it has become quite a serious problem, both on account of the crowded

condition in which the poor of that country live and the excessive intemperance which exists among them, this accident is of very frequent occurrence. There have been laws passed in England to prevent parents sleeping with their infants, and societies formed to insure the prosecution of those who break these laws. Though this has done much good, there are still numerous instances of infant suffocation from overlying by either drunken or somnolent parents. A recent case before the coroner may be briefly related:

A man and his wife had spent the evening together, drinking, and both went home in a condition described in the testimony as follows: "The husband absolutely drunk and the wife not so drunk, but under the influence of drink." On their way home the man engaged in a street brawl, sending his opponent to the hospital. The husband and wife then went to bed, taking their month-old infant with them, and in the morning it was found to be dead. On the advice of the nurse the mother had purchased a cradle for the child, but for want of bedding it had stood unused, except by the cat. The coroners jury found that there was negligence, but not culpable negligence, and returned a verdict of "Death from Suffocation." The jury agreed that the parents had rendered themselves liable. The National Society for the Prevention of Cruelty to Children instituted proceedings in the police court and both father and mother were sent to prison for two months. The judge told them that they were lucky to escape a charge of manslaughter. Physicians can not be too diligent in warning their patients against this pernicious and dangerous custom.—*E. S. McK.*

THE FIRST CESAREAN SECTION IN AMERICA.

April 22, 1912, there will be a gathering of medical men at Newtown, Ohio, a suburb of Cincinnati, to erect a tablet to the memory of Dr. John L. Richmond, who, on the 22d of April, at that place, performed the first recorded Cæsarean section in America. The complete history of the case has been worked out with remarkable painstaking care by Dr. Otto Juettner, of Cin-

cinnati. His paper, read before the McDowell Medical Society of Cincinnati, was published in the *Cincinnati Lancet-Clinic* January 27, 1912. For reprint, write Dr. Otto Juettner, Birkshire, Cincinnati. The patient on whom Richmond operated was a young primipara, who lived in a log cabin, which had been hastily thrown together for immediate occupation, and was unchinked. The waters of the Ohio and the Little Miami had combined to make a flood apparently to stay the doctor on his errand of mercy. Nothing daunted, he procured a skiff and rowed to the isolated cabin, and there, with one assistant, a woman, whose duty was confined to holding the one candle and protecting it from the blasts which roared on the outside from putting them all in darkness. The report of the case made by Richmond, and published in *Drakes Western Journal of the Medical and Physical Sciences*, Vol. 1830, p. 435, and is quoted in full in Dr. Juettner's address previously mentioned. Dr. Richmond graduated from the Medical College of Ohio in its first class, 1822, practiced and preached in Newton, and went through the cholera epidemic in Cincinnati in 1831, contracting the disease himself. He removed to Indiana, living in Pendleton, Indianapolis and Covington. He died in 1855, and lies buried in Springdale Cemetery, Lafayette, Ind. A granddaughter still lives, who is the wife of the American Consul at London.

The *Alienist and Neurologist* for February, 1912, contains the following articles of merit by noted writers of the country on the different subjects: The Asexualization of the Unfit (Barr); Is Genius a Sport, etc. (Kiernan); Measurements and Anomalies (Macdonald); Real and Pseudo-Expert Medical Testimony Before Courts and Juries (Hughes); Notes of the History of Psychiatry (Jelliffe). The above original articles, together with a large number of judicious Selections, and the usual number of Editorials, Reviews, Book Notices, Correspondence, etc., make a magazine of unusual value to Alienists, Neurologists, Savants, Lawyers and the profession in general.

ANATOMIST (MALE).
February 20, 1912.

The United States Civil Commission announces an examination on February 20, 1912, at the places mentioned in the list printed hereon, to secure eligibles from which to make certification to fill a vacancy in the position of anatomist (male), at \$1,600 per annum, in the Army Medical Museum, Office of the Surgeon General, and vacancies requiring similar qualifications as they may occur, unless it is found to be in the interest of the service to fill the vacancy by reinstatement, transfer, or promotion.

The examination will consist of the subjects mentioned below, weighted as indicated:

<i>Subjects</i>	<i>Weights</i>
1. Normal histology and physiology-----	20
2. Pathologic histology -----	20
3. Gross pathology (including preparation of museum specimens -----	20
4. Bacteriology (including care and use of microscope)---	20
5. Photomicrography -----	5
6. Training, experience, and fitness-----	15
Total-----	100

Applicants must have reached their twentieth but not thirty-fifth birthday on the date of the examination.

Men only will be admitted to this examination.

It is desired that the person appointed to this position shall be young, in good health, a graduate in medicine, have a thorough knowledge of pathologic histology, pathology, and bacteriology, be capable of making photomicrographs, understand microscopes, surgical instruments and appliances, and be able to prepare, card, and keep in order museum specimens.

All statements relating to training, experience and fitness are subject to verification.

In accordance with a recent act of Congress an applicant for this examination will be required to be examined in the State or

Territory in which he resides and to show in his application that he has been actually domiciled in such State or Territory for at least one year previous to the date of the examination.

This examination is open to all citizens of the United States who comply with the requirements.

This announcement contains all information which is communicated to applicants regarding the scope of the examination, the vacancy or vacancies to be filled, and the qualifications required.

Applicants should at once apply either to the United States Civil Service Commission, Washington, D. C., or to the secretary of the board of examiners at any place mentioned in the list printed hereon, for application and examination Form 1312. No application will be accepted unless properly executed, including the medical certificate, and filed with the Commission at Washington. In applying for this examination the exact title is given at the head of this announcement should be used in the application.

As examination papers are shipped direct from the Commission to the places of examination, it is necessary that applications be received in ample time to arrange for the examination desired at the place indicated by the applicant. The Commission will therefore arrange to examine any applicant whose application is received in time to permit the shipment of the necessary papers.

Issued January 15, 1912.

ATTENDANCE ON FAMILIES OF MEDICAL MEN.

A widow sold the practice of her lately deceased husband to a medical man, who went to reside in her house with a view of obtaining an introduction to the clientele. During his residence there he attended her cook and children professionally. Later a dispute arose as to the sale of the practice, and the widow brought suit to recover the purchase money. The defendant counterclaimed his fees for attendance. The plaintiff pleaded that it was the immemorial custom of the medical profession to attend the families of medical men without charge. Judge Scrutton said: "I am quite clear that although there is no binding

custom, there is a very general practice among medical men, to their honor, be it said, not to charge the widow and children of a recently deceased medical man for attendance. Where nothing was said there was an implied contract to pay a professional man his ordinary charges, that implication fell to the ground, where, according to the practice of the profession, the ordinary charges were not made." It will be seen that the learned judge did not extend the custom one inch beyond what was necessary to decide this case. He added: "I think that in a case like the present, if a doctor intends to charge he must say so, thus giving the patient the chance of declining his services and going to another doctor who will not charge." The judge's ruling could not be taken as an authority for the proposition that a medical man is bound, by custom, not to charge for the attendance upon a brother practitioner, his wife and family. If there is probability of abuse of this kindly custom he will do well to take the advice of the judge who tried this case.—*E. S. McK.*

LAW AGAINST SPITTING IN AUSTRIA.

Owing to the remarkable increase of tuberculosis in Austria, that government has passed a stringent law against expectorating in public places, making the fine 200 kronen, nearly forty dollars. The Austrian is, as a rule, a very easy going person, and it remains to be seen whether the law is enforced. Indeed it probably will not be, as the law has been promulgated for a year and not an arrest has been made. Experiments are under way in Austria to ascertain whether or not the dangers of promiscuous spitting in public places are so great as generally believed. These tend to show that the danger is much greater from the saliva than from the dust in the railway carriages which are frequented by tuberculosis patients. In Winnipeg, Manitoba, there is a fine of fifty dollars for spitting on the sidewalk, and it is pretty well enforced. Even the four-year-old Winnipegger is trained to go to the gutter when he wishes to expectorate. It would seem that this fine was excessive. A ten-dollar fine would be sufficient, more likely to be enforced, and not such a hardship when enforced.—*E. S. McK.*

PROFESSIONAL SECRECY AND INFANTICIDE.

A young woman was charged with the wilful murder of her child. Dr. Richard Brew, who had previously attended the girl, was called as a witness. He stated that anything which he knew was of a purely confidential nature as a medical attendant and claimed privilege communication. On further questioning he said that what he knew occurred about six weeks before the alleged murder. His claims of privileged communication was allowed.—*E. S. McK.*

Reviews and Book Notices

Practical Electro-Therapeutics and X-Ray Therapy.—With Chapters on Phototherapy, X-Ray in Eye Surgery, X-Ray in Dentistry, and Medico-Legal Aspect of the X-Ray, by J. M. Martin, M.D., Professor of Electro-Therapeutic and X-Ray Methods in the Medical Department of Baylor University, in the Medical Department of Southwestern University, and in the State Dental College, Dallas, Texas; Member of the Texas State Medical Association, American Medical Association, American Röntgen X-Ray Society, etc., containing 219 Illustrations. St. Louis. C. V. Mosby Company, 1912.

We are indebted to the enterprising publishers for a copy of this most valuable book. The author has succeeded admirably in presenting a book that will meet the wants of students and general practitioners in this progressive department of medicine in the most exceptional manner. It introduces only such features of the diagnostic and therapeutic work as will be of practical value to practitioners who have not time to devote to acquiring the requisite knowledge from more elaborate treatise on the subject. The work is well arranged and classified, and has been amply illustrated throughout. The use of the X-ray has of late become almost indispensable as a diagnostic agent, and its value as a therapeutic resource is becoming more generally recognized. We unhesitatingly commend the work to the profession as one that merits the fullest patronage of students and practitioners and feel sure that it will rapidly become popular with the medical profession.

Publisher's Department

Our readers will note in this issue for the first time the artistic advertisement of Palpebrine, the safe and reliable remedial agent in all external inflammation of the eyes. This product is manufactured by the Dios Chemical Co., who have, during the last quarter of a century, manufactured exclusively for physicians, Dioiburnia, Neurosine and Germiletum, the reliability of which is generally recognized.

No new and untried drugs enter into the composition of these specialties, and their formulae have always been communicated to the profession. Palpebrine will fill a long-felt want of the general practitioners, who can themselves treat with this product, safely and successfully, external inflammation of the eyes.

The Dios Chemical Co., of St. Louis, will mail free, trial bottle of Palpebrine on application.

SODIUM SALICYLATE THE REMEDY FOR RHEUMATISM.

"When a diagnosis of rheumatism has been made, it then behooves one to cast about for some agent that will quickly arrest the process and avert complications. For this, one remedy stands out preëminently — namely, salicylates. Preference should be given the sodium salt. Some do not regard this favorably, and it is these who may have an instrument they do not know how to wield. Plehn has pointed out the "stumbling block" for these, showing that success depends upon adequacy of dosage, and he further observes that the salicylates are as much a specific in acute articular rheumatism as quinine in malaria or mercury in syphilis."

"One strong objection advanced is the inability of the patient to retain the medication because of the nauseating effect. Sodium salicylate has a very sickening sweet taste and should never be administered except in the form of a solution."

The natural salicylic acid in Tongaline will not cause the disturbances that accompany the use of the synthetic product, which

is invariably dispensed unless the natural salicylic acid is specified. Hence Tongaline is a most desirable vehicle for the administration of natural salicylic acid.

RHEUMATISM.

These are few diseases in which Iodia is more servicable than rheumatism. In some of the chronic types, characterized by the depressing joint affections that make life a burden, Iodia will be found well-nigh a specific. It relieves pain and soreness in a manner quite remarkable, and gives the patient more comfort than has been known for months. Likewise, many of the myalgic forms respond at once to Iodia, and lumbago usually clears up rapidly under its use. Iodia does not conflict with other anti-rheumatic remedies. On the contrary, it is a powerful synergist and greatly augments the action of the salicylates and similar remedies. Iodia should be given in two teaspoonful doses three or four times a day.

Notwithstanding the large number of Hypophosphites on the market, it is quite difficult to obtain a uniform and reliable syrup. "Robinson's" is a highly elegant preparation, and possesses an advantage over some others, in that it holds the various salts, including iron, quinine and strychnine, etc., in perfect solution, and is not liable to the formation of fungus growths.

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NASHVILLE JOURNAL — OF — MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

VOL. CVI.

MARCH, 1912.

No. 3.

Original Communications

DISEASES AND DEGENERATIONS DUE DIRECTLY TO ALCOHOL.

BY T. D. CROTHERS, M.D.,
Superintendent Walnut Lodge Hospital, Hartford, Conn.

The time has passed for the discussion of theories, personal opinions and traditions concerning the value of alcohol as a beverage, food or medicine. The accumulation of facts from research work in laboratories, hospitals and accurate clinical studies, supported by practical experience, have taken the subject out of the field of theory, opinion and speculation.

Active practitioners, surgeons and specialists, find that every new study of causes and conditions, brings into increasing prominence the intimate relation of alcohol, as an active and predisposing agent, in a great variety of diseases and degenerations.

My purpose is to outline some of the more prominent of these, which are traceable to a very large extent to the use of alcohol, and indicate their importance in all the questions of diagnosis, prognosis and treatment.

ALCOHOLISM.

This term implies the traditional theories of vice, wilfulness and moral weakness. Even among medical men, it is regarded often with contempt and the question of disease, considered insignificant. In reality, the symptoms are most pronounced of

delirium, paralysis, poisoning and acute irritation, anemia and disturbed organic and functional activity, and there are no causes known which will produce the same complex symptoms.

Lead, arsenic and other mineral substances are capable of producing poisoning with symptoms that resemble it, but when compared there is a wide difference. The alcoholic complex symptoms which vary in different persons, and yet they follow a uniform line and progressive movement that is unmistakable.

Acute intoxication with or without delirium is always associated with stupor, and may be due to other causes than alcohol, and yet, alcohol as a cause is marked by some specific, special symptoms that are not easily confounded with others.

Alcohol may be a symptom and not a special exciting cause, hence the symptoms may differ. The most pronounced types of alcoholism are persons who use spirits steadily, often in small quantities.

Such persons are continuously poisoned, and whether aware of it or not, there is marked organic deterioration and perversion of the cell and tissue, which breaks out in some form or other, sooner or later.

A healthy person may take large quantities of alcohol and become acutely poisoned, but this ends in sobriety and restoration, but the man who drinks spirits, even in small quantities, steadily, has no period of rest for recovery and relief.

Alcoholism describes persons suffering from most complex degenerations as the direct result of the one specific cause.

INEBRIETY.

This term, like that of alcoholism, is not clear to many persons, and is used in a confusing way, but literally it is the name of a class of symptoms, pointing to a disease, which follows from the use of spirits taken with great irregularity and at long intervals.

The period between the use of spirits is one of apparent health in which no spirits are used, and the patient seems to be healthy and well. Then suddenly some distinct obsession provokes the use of spirits up to the point of excess, marked by a variety of symptoms which are termed in a general way, insanity.

There is a distinct storm session, resembling epilepsy in intensity and impulsiveness, which after a time passes off. This drink period may come on suddenly or slowly, beginning in an insignificant way, and then gradually growing up to full development, marked by irritation, delirium, anesthesia, then narcotism and a period of revulsion, disgust and practical immunity.

The free intervals may be uniform or irregular in their duration, but after a time become shorter and more marked. The attacks apparently seem due specifically to alcohol, and yet back of that, there are pathological and psychological conditions which provoke and appear in the demand for the relief and narcotism of alcohol.

There are some physical and psychical centers of irritation and psychoasthenia which precede these attacks.

Literally, the use of alcohol is a symptom, as well as a cause, and the first use creates an intense desire for the continuation of its use. Some profound disturbances of both functional and organic activities comes over the system and find relief in spirits, which brings anesthesia and rest. There is in this psychical impression that nothing can take its place, and bring such positive help. Innumerable instances indicate that both the taste and smell of spirits are repulsive and its effects dreaded, and yet the impulse to drink is irresistible.

Such persons go down through life held in the grip of a pathologic and psychologic force, which, with or without any active exciting cause, gathers and breaks at intervals in profound toxemia.

Here is a field for medical practice and medical help that is literally unoccupied, except by quacks and a few pioneers. These two diseases—alcoholism and inebriety—while closely allied in symptoms, differ widely in causes, and yet follow a uniform line, and move with a positiveness that can be predicted and studied, and all date to alcohol as the active and predisposing cause. They are both mental and physical conditions, and the possibility of cure and prevention, when known and treated by rational means, is, to say the least, startling.

There are a number of diseases which follow these conditions, which are called terminals—stages—marked by acute inflammatory infections in the organs. These appear from a study of a large number of cases, and are put down in the mortality list without reference to the actual causes.

PNEUMONIA.

Statistical studies of fatal cases of pneumonia indicate from 50 to 70 per cent in which there is a history of excessive use of spirits. These are the highest and lowest estimates, and hospital statistics amply confirm them. Pneumonia, nephritis, meningitis, and gastritis, are terms that describe the terminal stages of the alcoholics and inebriates.

The late Dr. Richardson of London called these cases pneumoparesis, in which paralysis of the branches of the pneumogastric nerves occur, dating from some central cause in the medulla, resulting in sudden palsy of the capillaries, terminating fatally in a few hours. These cases are by no means uncommon. Both inebriates and alcoholics are particularly liable to sudden death from pneumonia. The real causes are not understood, and are usually ascribed to chills, change of temperature, etc.

Acute clinicians and surgeons make a guarded prognosis where a person with an alcoholic history is taken ill with pneumonia.

Profound intoxication from spirits acts on the vital powers of cell and tissue, suspending them and diminishing the resistance to congestions and the growth of germs.

The same thing occurs in nephritis, with a sudden breaking down of cell and tissue from acute inflammatory action. Gastritis and meningitis manifest the same forms and conditions.

The anesthesia of alcohol has suspended their functional activities beyond the point of restoration, and collapse and inflammation follows.

CEREBRAL HEMORRHAGES.

The so-called apoplexies, shocks, hemiplegias and other forms of general and local paralysis, are common terminal diseases in

persons with an alcoholic history. Here statistics show a large proportion of fatal cases from this disease due to this one cause.

There is a great wealth of illustrative cases in this field.

The direct effect of alcohol on the vasomotor nerves in diminishing their contractile power and increasing the tension is a very active predisposing cause. All persons who use spirits show a high degree of arterial tension and sharp tendency to congestions.

The arteries in the alcoholic and inebriate, are practically vulcanized, the muscle cells being replaced by fibrin and the walls rendered thick and hard. In all probability this excess of fibrin and deposits in the walls of the arteries, extends to all other organs. The brain, in particular, suffers, and as a result, fractures occur, with local or general palsies.

Cerebral hemorrhages should always suggest alcohol as an active or predisposing cause, and the question of treatment should turn on this fact. Illustrations are very common in every day experience of this condition, and while not always fatal, the invalidism and defects which follow are serious.

NEURITIS.

Inflammations and degenerations of the neurons of the terminal nerves (called rheumatism by many persons) is one of the most common terminal diseases that follows from the use of alcohol. Both the alcoholic and inebriate rarely escapes this affection, although referred to other causes.

The fact that the toxins from spirits circulating in the blood have a particular affinity for the brush ends of the nerve terminals, and set up inflammatory foci, is clearly recognized. The pain and irritation is reflected along the muscles and in distant parts of the body.

Cramps in the muscles, continuous or spasmodic pains along the nerve trunks, hyperesthesia or anesthesia of the muscles, are the most common symptoms.

Alcohol seems to be the most common of all the causes, and nearly all inebriates and alcoholics exhibit symptoms of this condition. The almshouses, and the insane asylums have a great

variety of illustrative cases, and the incurables in every town and city, with an alcoholic history, bring out the fact of local inflammatory erosions of the nerve terminals.

There are other prominent diseases and terminal degenerations which refer specifically to the toxins of spirits and the action of alcohol on cell and tissue. Modern literature and recent textbooks contain such names as alcoholic epilepsy, alcoholic mania, dementia, paresis, idiocy and so on. The word alcohol is used to describe the most common and prominent cause. These indicate beyond question the tremendous advance in the etiological studies of the exciting and contributing causes of disease. At present they only outline a few of the conditions directly resulting from alcohol.

Beyond this, there is a large unknown range of active and contributing causes which enter into the production of disease, awaiting exploration, with an equal promise of revolutionary discoveries, equal to that of germ diseases.

DEGENERATIONS DUE TO ALCOHOL.

This term describes morbid changes, reversions from the normal, the breaking down of cell and tissue, and the promotion of diseases conditions and susceptibilities to disease. In a general sense, it must be understood to mean, both functional and organic, diseases and tendencies to break down.

Among the very common degenerations following from the use of alcohol is its effects on cells and neurons. First, the dehydrating qualities of alcohol, outside of its oxidization, falls most heavily on cell growth and cell activity.

The sudden abstraction of water changes the form and structure of all cell life. Persons who have died under the influence of spirits show cell wreckage, distortion, corrugation and shrunken cells, both of blood and serum.

Persons intoxicated show these cell changes, which pass off after the anesthesia of alcohol has disappeared. Laboratory experiments on animals that are given spirits show marked erosion of cells and neurons, peculiar to those who receive spirits, and not seen in others.

Second, there is a distinct anesthetic action on the cells and their activity. Their movement is suspended, checked and diverted, and this is also measurable by laboratory experiments. From large quantities of spirits, cell anesthetics may extend over large areas, from small quantities, the effect are not noticeable, and yet they exist.

Third, there are changes in the metabolism, shown in the plasma and chemical changes in the food products. The normal conditions are broken up. There is an excess of fibrin and fats. The oxidizing processes are changed and new products are formed, which become toxic, and are carried to all parts of the body.

In the alcoholic who uses spirits continuously, these changes are marked by low vitality, deranged heart's action, disturbed nutrition and faulty reasoning. The beer drinker, who uses small quantities of beer, loaded with ferments and foreign products, shows excessive development of fat over the abdomen and about the heart, with morbid growths, deposits and perversions of fibrin and fat compounds.

The excess of fibrins in the walls of the arteries bring about changes that tend to derange and pervert the normal rhythmic flow of blood plasma. Very interesting experiments, or rather utilization of these facts, are carried on in dog kennels, where, by feeding small quantities of alcohol, the growth of the animal is suspended; and this, carried on for one or two generations, develops in a new breed of dwarf dogs. The toy dogs are all the direct result of breeding and the use of alcohol to prevent growth.

This is further illustrated in emigrant women and others, whose children have been given wine and beer in early life in place of food. Their impaired growth and vigor is a striking illustration of the degenerate effects of alcohol.

A clinical fact of great significance is the sudden flush noted in the capillaries of the face from the ingestion of a small quantity of spirits. This is a literal palsy of the vasomotor centers. Later, where spirits are taken continuously, it becomes more or less permanent, and extends to the nose and cheeks, and are facetiously called "rum blossoms."

In reality it is not a local condition, but extends to the entire capillary system, and is most significant of general vasomotor paralysis and deranged circulatory action.

The hardening of the walls of the blood vessels may result in a blocking of the currents, cutting off the nutrient supplies in certain areas, followed by anemia and hyperanemia.

It would be difficult to forecast the general or special degenerations following from these derangements of the circulation, and yet it is clear that profound changes exist, are going on, and possibly localizing in certain sections.

Another clinical fact is not often recognized, that in addition to the alcohol taken in the system, there are chemical and metabolic changes, which result in new toxins and compounds that still farther increase the derangement.

The term auto-intoxication describes conditions that exist in all cases not recognized. Nutrition shows this in the pronounced changes and disturbances, and gastritis is a name for the effects of direct agents taken with and formed from the action of alcohol. The derangement of the intestinal canal brings further evidence. The number of foreign products seen in the urine are indications of this injury. Thus indican, cholin, lecithin and phosphorous compounds, with nitrogen-sulphur excretions, are all toxic products formed and thrown off.

Albuminuria and glycosuria so prominent in extreme alcoholic stages are still further evidences. In delusional and convulsive conditions, both the urine and blood exhibit the presence of toxic bodies referable to alcohol.

There is a large number of cases where the symptoms of degenerations are obscure, and yet, clearly present. Such persons later pass into the penumbra of insanity with or without exciting causes. The fact of having drunk spirits is an unmistakable indication of lower vitality, increased susceptibility to disease of all kinds.

Studies of fatal cases among mill operators and men in the transportation business bring out this fact. Persons who are injured by blows on the head, broken bones and lacerated wounds

that are of a trifling character, exhibit grave symptoms and fatality that is unusual and startling. Further inquiry shows that they are alcoholics and inebriates. The presence of an epidemic shows unusual gravity and fatality in persons of this class. The sudden deaths of apparently vigorous, strong men, from obscure and insignificant causes, have the same history, which points unmistakably to some form of degeneration, predisposing and encouraging this condition.

The great borderland degenerations and obscure diseases called paranoias, neurasthenias and other vague names in which the symptoms are entirely out of proportion to the supposed causes, when examined, date back to alcohol as a cause, both exciting and contributing. There is a wealth of illustrative cases and facts in this field which have not yet been studied except in individual instances.

There is one conclusion that forces itself with startling significance on the mind of every practitioner. Here is a field of causes and conditions following with possibilities of medical help, prevention and correction that is practically unrecognized.

Armies of laymen and reformers, with a dim conception of the danger from this source, are making most herculean efforts to overcome the evils entirely from a moral and theological point of view. Recently, unscrupulous quacks, with claims of specific remedies, and results that border on the miraculous, are occupying this field, seeking to take advantage of the feeling of alarm and possibility of medical help, that is growing in all sections.

The entire problem is a medical one, requiring the highest kind of scientific skill and discernment to trace the results from certain causes and point out means and methods of cure, and yet the profession as a class stand aloof and look on the efforts of laymen and quacks with distrust and doubt.

The physician of all others should be the teacher and authority concerning the use of alcohol in every community. The problem is a medical, hygienic and scientific one. There are no ethics or morals in this question of facts. There are no disputed questions of prohibition license, control and punishment of the victim. These

belong to laymen and non-experts who know very little of the great underlying causes.

Empiric methods and means, with marvelous results, are parts of the history of every great advance in science. A new field of medical work is open at our doors and quacks and reformers are forcing it upon public attention.

Great armies of alcoholic-diseased men and women are seen in every community. They are mutely calling for help. They appeal to the medical men for means of relief, cure and prevention, and like the Levite, we pass them by on the other side.

There are no theories in this. It is a question of facts, and their meanings and the medical profession are called by every consideration of duty and obligation to study and recognize these conditions. The few pioneers in the field show the possible means of prevention and cure from a larger knowledge and more thorough understanding, and are calling everywhere to their brothers in the profession to come up and occupy this new field of practice.

This is the imperative need of the hour, and this is the new land for medical study at our very doors, white for the harvest, with possibilities beyond any conception of the present.

THE OFFICIAL PREPARATIONS OF THE U. S. P. AND N. F.

In view of the ever-increasing popularity of the official drugs and preparations of the United States Pharmacopocia and the National Formulary among the member of the medical profession, it may be interesting to note a few reasons for this fact.

These official preparations are of a definite and known composition and strength; they are active therapeutically; they are economical to use; all the ingredients being known there is no occasion for prescribing contraindicated drugs; their titles as used in prescription writing can not be read by the laity, hence self-medication is manifestly rendered almost impossible.

To supply our readers with authoritative information regarding these preparations we have determined to establish a department in our journal with the above heading and to each month discuss two or more of these preparations. This month we will feature the Compound Syrup of White Pine N. F., and Tincture of Digitalis, U. S. P.

SYRUPUS PINI STROBI COMPOSITUS, N. F. --

The Compound Syrup of White Pine, N. F., represents in each teaspoonful dose, the following: 5 grains each of White Pine bark and Wild Cherry bark; $\frac{5}{8}$ grain of Sassafras bark, and contains also 1-32 grain of Morphine Sulphate and $\frac{1}{3}$ minim of Chloroform.

The Sugar-content is 75 per cent and the Alcohol-content is 6 per cent. May be given in doses 4-8 Cc. ($\frac{1}{2}$ fluidrams).

Probably no similar preparation of a like nature or of a proprietary character has such effective sedative expectorant properties. It has a pleasant taste and may be prescribed in connection with other expectorant remedies if desired.

The ingredients of this preparation are well blended. The aromatic properties of the sassafras and the stomachic properties of the wild cherry serve to control any irritability of the stomach, which often manifests itself in the administration of cough remedies. The antiseptic properties of the balsamic resin in the Balm of Gilead also serve a most useful purpose in removing any bacterial inflammation present.

Occasions may arise where the use of morphine is objectionable in this syrup. In such cases it may be omitted. It can also at times be replaced by menthol with advantage. Otherwise, however, the combination is a good one and ought not to be interfered with.

The expectorant action of this syrup is mainly to diminish secretion, and it would therefore be an improper remedy where an increased secretion is the object sought. The choice of expectorants must be governed by the condition of the mucus, and in a measure by the general condition of the patient.

TINCTURA DIGITALIS, U. S. P.

Tincture of Digitalis represents 10 per cent Digitalis, and contains about 46 per cent of Alcohol. Its dose is from 0.3 cc. to 1.5 cc. (5 to 25 minims). It has a brown color, with a suggestion of green, a narcotic odor characteristic of the drug, a somewhat bitter taste, and is miscible in all proportions with alcohol and water.

While some clinicians endorse the therapeutic use of isolated Digitalic constituents, these are mostly in the experimental stage as yet, and accordingly, most practitioners favor the standard U. S. P. tincture for reliability.

Digitalis produces a direct stimulation of all forms of muscular tissue, of the vagus ganglia, and of the medullary centers, the most useful being the stimulation of the cardiac muscle, producing a more powerful systole, and later a lessened diastole. It is undoubtedly the most valuable remedy at the command of the medical profession in cardiac and renal dropsy.

Most authorities are agreed that the recumbent posture must be maintained when the drug is given for its full cardiac effects. If given for any length of time the heart is so strained by overstimulation that on suddenly assuming the erect position the cardiac energy may fail, and especially if the doses are administered too closely together.

Digitalis is slow in action, requiring from thirty-six to forty-eight hours to manifest its full intensity. A common mistake is often observed in that too large a dose is prescribed at first which tends to premature arterial contraction and cumulative effects. Elimination of Digitalis is also effected very slowly.

It is contraindicated in a slow pulse due to weakness of the heart wall; an incompetent aorta; dyspepsia; any form of cachexia, where the drug has already been used for some time; and it should also be given with great care to persons with fatty degeneration of the heart and dilation.

A point worth remembering is that when the cardiac effect of Digitalis is desired the tincture should be employed, and the ingestion of any aqueous fluid be prohibited within thirty minutes,

either before or after swallowing a dose. If the diuretic action is required, the proper preparation to use is the infusion (Infusion Digitalis, U. S. P.). This infusion represents the aqueous extract of two grains of Digitalis to each dose, an average dose being 8 cc. (2 fluidrams).

The reason for this is that those active principles of Digitalis which are soluble in alcohol (represented by the tincture) produce the characteristic cardiac effects of the drug, while those principles soluble in water (represented by the infusion) produce the diuretic effect.

Selected Articles

CHOLECYSTITIS ACUTISSIMA HAEMORRHAGICA.

BY PRIVATDOCENT DR. BRUNING,
of the Surgical Clinic at the University of Giessen.

(Translated from the *Deutsche Zeitschrift für Chirurgie* for the *Nashville Journal of Medicine and Surgery*.)

BY HOWARD S. JECK, M.D., NASHVILLE, TENN.

He who frequently examines surgically removed gall-bladders by microscopical methods, will make the observation that the clinical symptoms and the pathological-anatomical findings by no means always correspond; indeed they oftentimes appear to be contrary to each other. It is especially the clinical picture of acute cholecystitis in which one frequently misses an anatomical finding which explains the severity of the condition. While in some cases there are found severe necroses of the mucous membrane, in others one sees—and these are not the lighter cases by any means—changes in the wall of the gall-bladder which are, microscopically, hardly perceptible.

The correct diagnosis of a disease as cholecystitis acuta is frequently difficult for the one who is skilled, so that it is not to be wondered at if, under the unfavorable circumstances of a general practice, incorrect diagnoses, such as appendicitis, intestinal obstruction and gastric perforation are frequently made. An acute inflammation of the gall-bladder is characterized especially by the fact that it begins very suddenly with most severe symptoms. We have at once the picture of a very sick patient before us. Violent pains, which are at first always located at the right costal arch, radiate over the whole right side of the abdomen and soon toward the left. In the back between the shoulder blades and in the right arm, the patient complains of twitching sensations and sharp pains. The body is sensitive to every movement, so that on account of marked tension of the abdominal muscles, there is

frequently nothing to be gained by palpation. One oftentimes feels the liver and the enlarged gall-bladder, which may extend down so far that a confusion with appendicitis is likely. The arterial system shows the signs of collapse, a small, hardly perceptible pulse, a pale face covered with sweat. The condition of the temperature is variable; high fever may exist, still there are found cases which show hardly a moderate rise. If gangrene of the bladder is imminent, peritoneal symptoms tend to set in. Eructations and vomiting are a frequent manifestation in the further course of cholecystitis acutissima. If, in addition to the above a reflex intestinal paralysis is associated, so that for several days no stools pass, and the evacuation of flatus likewise ceases, one may well consider an intestinal obstruction. The history in consideration of a gall-bladder disease is not always reliable; many times the patients have never complained before; at other times stomach cramps or enlarged livers have existed for years. Only occasionally is a diagnosis of cholecystitis made earlier.

Concerning the pathological-anatomical changes of the gall-bladder, we have yet no very consistent description. As remarked in the beginning, one sees in cholecystitis acutissima all transitions from a slightly altered mucous membrane to one of a high degree of destruction. In these latter most severe forms, the contents of the bladder is at times mixed with blood, which either extravasates with the leucocytes through the vessel walls or comes from the capillaries opened by the necrosis of the mucous membrane. These quantities of blood may appear so prominently that one speaks at once of a cholecystitis hæmorrhagica. Yet, according to the experience of Kehr and Körte, larger hemorrhages occur, though rarely. On that account, I should like to report here a case of cholecystitis hæmorrhagica acutissima, which stands out from among the 1,600 cases operated upon for gall-bladder disease in this clinic.

On the 1st of September, 1908, I was called away to see a woman sixty years old, in whom ileus was suspected. The history showed that the patient had suffered of late years from attacks of weakness and dizziness, and was treated by her family

physician for myocarditis. Disturbances on the part of the liver, stomach and intestinal tract were never recorded.

Eight days before, during a ride on an electric car, the patient perceived a violent pain in her abdomen, which she was not able to localize more definitely. The patient was put to bed and the condition improved somewhat, but a marked thirstiness set in. The patient looked strikingly pale. She remained in bed for days. Only occasionally was there a bowel movement, slight in quantity, but of normal appearance. On the eighth day, another attack of pain came on, much more violent than the first, and which was only alleviated by large doses of morphine. The pain seemed to be located over the whole abdomen and radiated toward the back. There was no passage of stools and flatus, though several different kinds of enemata were given; a purgative was likewise followed by no result. During the whole course of the disease, there was no nausea. On the evening of the second day after the last attack, I saw the woman.

Status Presens.—For her age, a robust woman, and not very fat. Skin and mucous membrane pale; very languid facial expression; pulse small, accelerated, intermittent; no fever; abdomen somewhat distended, but without especial tension. There was no intestinal peristalsis visible; no intestinal sounds were heard. You could feel in the right side of the abdomen a very painful resistance, which at its beginning at the right costal arch was broad and diminishing in size from above downwards, extended below the level of the umbilicus. The surface of the tumor felt uneven. Ascites was not demonstrable. The diagnosis of cholecystitis acutissima was made. There was probably a threatening gangrene of the gall-bladder, or already a consequent perforation into the omental adhesions.

The patient agreed to the proposed operation, which then could be done in Giessen under more favorable conditions than in smaller places. The patient bore the trip well. Patient did not grow worse, still there was no improvement.

The operation was done under scopomorphin—chloroform narcosis—vertical incision in right rectus muscle. The right lobe of

the liver was widely displaced; the greatly enlarged gall-bladder extended a good four fingers' breadth beyond it. The omentum had wrapped itself around the gall-bladder and was adhering lightly to it. After the separation of the protecting part of the omentum, the blue-green, gangrenous, discolored fundus of the gall-bladder could be seen. Since the gall-bladder was filled to such a degree of distention that one had to fear its bursting, it was punctured. But in spite of the large trochar and canula, no entrance could be gained. On sticking the trochar in, it felt like a firm hard mass. On further examination, we found the serosa of the bladder wall reddened, and in places covered with fibrin. The cystic and common bile ducts were not enlarged, and no stone could be palpated in them. In Glisson's capsule there was a slight edema.

The freeing of the bladder from its fossa in the liver, and its removal from the cystic duct, offered no difficulties. A branch of the cystic artery spurted and was ligated. From the cystic duct clear bile flowed. In the common bile duct there was no stone found on sounding, and the duodenal papilla was patent.

Drain and tampon were applied to the ligated stumps of the cystic duct. Abdomen then sutured. Uninterrupted recovery, without complications. Highest temperature on the second evening, 37.2°C (99° F). On the fourteenth day, the patient left her bed. In order to avoid thrombi and hypostasis, breathing exercises were carried on and the patient instructed to move her legs amply. She always sat up in bed.

Later Progress.—A year after the operation the woman reported she felt entirely well. She has never again had the slightest trouble.

The Preparation.—The cystic duct was narrow at the place where it was severed. The swelling of the mucous membrane, which was overcome by a sound, prevented open communication with the bladder. The latter itself was greatly enlarged, its walls thickened (1.5 c.m.), edematous and hæmorrhagic. In the bladder no stones were found, only little firm cruor masses, having a shell-like form and similar to the blood coagulum in an aneurismal sac. The mucous membrane was apparently completely lack-

ing, for you could see only firm reticulated connective tissue. Towards the fundus, there were many $\frac{1}{2}$ -1 m. m.-sized openings similar to the openings of vessels from which black, hard thrombi projected. The discolored gangrenous portion was very thin, nearly perforated.

Microscopic.—Cystic duct. The mucous membrane showed well developed folds with epithelial surface preserved. The submucosa was loosened by an edema, rich in fibrin. The muscularis showed small-celled infiltration in places, besides numerous extravasated red blood corpuscles. The connective tissues was not increased. The arteries and veins were without pathological change. Every indication of arteriosclerosis was lacking. The elastic fibres formed in the submucosa a thick, variously interwoven network. On the serosa lay edematous aggregations of fibrin and cells.

Neck of the bladder.—The mucosa was lacking completely or was changed into a homogeneous mass not taking a nuclear stain, in which you could still recognize widely dilated and filled vessels. Under the otherwise normal muscular layer was a broad layer of tissue saturated with extravasated blood. The whole bladder wall was loosened by edema. In a few places there was a small-celled infiltration. Vessels normal.

Body of the bladder.—Mucous membrane and submucosa were lacking or were necrotic. The muscularis was torn apart by blood and edema, rich in fibrin. The chief part of the blood also lay here toward the outside under the serosa.

Fundus of the bladder.—Mucous membrane and submucosa were lacking. The wall was thin on account of the lack of edema. This part of the gall-bladder had evidently been under high pressure. There was no free blood in the tissue, but it had collected in larger cavities communicating with each other and was coagulated. In some places, the bundles of muscles, limited toward the inner side, were forced apart and the space situated intramurally opened itself on the inside of the bladder, into which the coagulated blood projected. There were the microscopically visible openings with their firm thrombi. Serial sections showed that

the spaces had no connection with blood vessels but were lymph spaces widened by the collecting of the blood. From the endothelium, no organization of the thrombi masses had begun. Bacterial staining gave a negative result in all the different sections.

To briefly recapitulate: In an elderly woman who apparently had never suffered from an inflammation of the gall-bladder, such a condition suddenly appears and with unusual violence. After an endurable interval of eight days, a new attack of pain follows, which brought about an operation. A gall-bladder over-distended to the extent that gangrene threatened, is found, and contains coagulated blood only. Also microscopically is found no indication of previous inflammation. There is, accordingly, a *cholecystitis acutissima hæmorrhagica*. In the absence of every other reason, the hemorrhage is to be explained only by the fact that in consequence of a sudden bacterial infection, swelling of the mucous membrane, edema and hemorrhage came on. The mucosa became necrotic, perhaps, through compression of its vessels by the inflammatory edema, capillary lumina were opened and now sent their blood partly into the lymph spaces, partly into the gall-bladder direct. The hemorrhages must have taken place fairly suddenly, and yet, I believe it follows, from the shell-like nature of the coagula, that several hemorrhages resulted, and not two only as one might think from the history. That, later, the examination for bacteria was without result does not argue against an infection, since we not infrequently find sterile bile in acutely inflamed bladders. The obstruction of the cystic duct, which in many cases of acute cystitis is brought about by a stone, was in this case solely caused by the swelling of the mucous membrane, aided perhaps by an angularity at the neck of the bladder. As mentioned before, similar cases have been seldom described in the literature.

At the Surgical Congress in 1904, Rehn, in a discussion of observed cases, reported briefly a pertinent case which had been diagnosed as intestinal obstruction, and by the operation for that condition, an enlarged gall-bladder, filled with blood, was brought to light. Microscopically there was the picture of a *cholecystitis acuta hæmorrhagica*. In the bladder were stones, which might

easily have caused ulcers by pressure and erosion of the vessels.

Köre cites in his "*Chirurgie des Gallenwege*" (Surgery of the Biliary Ducts), a case in which the bladder firmly adherent to the neighboring viscera, contained 100 c.c. of bloody fluid and many blood clots, in which numerous pea to bean-sized stones were imbedded. The microscopical diagnosis here also pointed to cholecystitis acute hæmorrhagica.

In conclusion, Pereira and Harris (Lancet, 1906), report the case of a woman whose history of her sickness has the greatest similarity with my case in so far as the manifestations of hemorrhage appeared so conspicuously. The afflicted elderly woman had already had many attacks of gall-stone colic, which subsided best when she would take a walk. When she in a particularly violent attack, employed again her usual remedy, she was so overcome by a feeling of faintness and languor that she had to be helped home by strangers and put to bed. She presented the picture of collapse, was pale and delirious. On examination, no enlargement of the liver or gall-bladder was found; however, there was a sensitiveness to pressure at McBurney's point. Pulse 100, temperature normal. Marked thirstiness. In the course of a few days there developed a resistance in the upper right side of the abdomen, which extended to the anterior superior iliac spine. Since the temperature rose to 37.7C (99.9F) and the pain increased, steps were taken to operate. Cholecystostomy in two sittings. In the bladder were raspberry-colored mucous membrane and innumerable little gall-stones. The authors rightly designate the condition as an acute hemorrhagic cystitis.

In all these cases cited, stones were found in the bladder, which, perhaps, through the formation of ulcers, due to pressure, might be made responsible for the hemorrhage. However, I do not believe that this is the proper explanation. In these three cases, as also in mine, one should consider the hemorrhage as a symptom of the acute inflammation of high degree.

I have called the disease running the very fulminating course cholecystitis "acutissima" in order to reserve the expression "acuta" for the less severe attacks.

It would yet be well to consider if one should not treat such a disease expectantly or be satisfied with a cystostomy. I believe the operative findings, the imminent gangrene of the bladder, justify our procedure. Cystectomy, however, is in our clinic the operation of choice, from which we depart only under very pressing contraindications, since it alone can guarantee a lasting cure.

Extracts from Home and Foreign Journals.

SURGICAL

MASTOIDITIS, A SYMPTOM OF.

The author calls attention to a symptom which is often present in early, doubtful cases of mastoiditis, and which he considers valuable as corroborative evidence. The symptom consists in a blurring of the outline of the mastoid tip as contrasted with that of the healthy side. It is quite distinct from any localized swelling, such as precedes a perforation of the mastoid cortex in the formation of a subperiosteal abscess, or a case of Bezold's mastoiditis, and is elicited by grasping the tip of the mastoid, anteriorly and posteriorly, between the fingers of one hand while exercising a control with the other hand on the healthy tip of the other side; the difference of definiteness of outline is then easily appreciable.

In a large number of cases of acute mastoiditis, the presence of this symptom in conjunction with an acute middle-ear suppuration led the author to operate, though the patient was apparently progressing as favorably as usual, and in every case the operative findings confirmed the value of the symptom as an indication for operation. Of course, a negative finding has not the importance attached to the positive.

The swelling from otitis externa may sometimes lead to doubt, but this form of swelling is almost always reduced in a few days by local treatment and the use of the ice-bag, upon which event the above symptom becomes manifest if an acute mastoiditis exists.

The blurring of the outline of the mastoid is due to a mild inflammatory infiltration of the periosteum and adjacent soft structures, brought about by their juxtaposition to the underlying inflamed bone. H. A. Alderton (*Medical Times*, January, 1912).

NON-UNION OF FRACTURES.

The fault in true non-union of fractures, according to J. S. Horsley, Richmond, Va. (*Journal A. M. A.*), is due to the failure of the tissues to deposit lime salts, and after excluding all local and constitutional causes there still remains a group of cases in which this condition seems to occur and the bones fail to unite. There are two indications for the treatment of these cases, namely, to increase the quantity of lime salts in the blood, and, second, to induce a larger quantity of blood-flow through the affected bone. The first indication is met by the administration of calcium salts, usually in the form of hypophosphates. Thyroid extract has been recommended, but its methods of action is uncertain and reports are conflicting as regards its efficacy. It may, however, act as a hormone. The diet and personal hygiene must, of course, be carefully attended to. The second indication, increasing the circulation, must be carried out by local measures, and Horsley recommends the introduction of a sterile foreign body into the tissues to induce hyperemia. This idea was suggested to Dr. Charles Mayo by the fact that a sequestrum or a clot induces a growth of new bone around it. He therefore uses a sterile ivory pin in the medulla of the bone in cases of ununited fracture. It does not fit tightly, is unabsorbable, and instead of the ends being smooth they should be a little jagged, so as to induce blood-clots and hyperemia. Another useful measure is Bier's hyperemia, obstructing the venous circulation for from ten to forty minutes every day. An important matter is the amount of bone to be made. Frequently in these cases the ends of the bone are one solid mass, which exhausts and blocks off the nutrition. Hence it is advisable to drill out the end of the bone and expose the medullary cavity, which is best done with a burr, though a small chisel may be gently used to enlarge the opening. Horsley reports a case, showing the difficulty of nutrition in these cases. The matter of fixation of the fracture is probably the least important matter. With good personal hygiene, absence of constitutional trouble and observance of the local indications, such as cleaning out the ends of the bone and roughening them and in-

serting an ivory pin inside, it matters little what method of fixation is used so the limb is put in its proper axis. He uses a silver plate fastened by one or two screws in each end of the fracture. This is best placed on the periosteum, or if that has been denuded, it should be sutured around the plate. The wound is closed without drainage and a plaster-of-Paris cast or some other splint applied. The retentive apparatus should be used for several months, changing it every few weeks. After three or four weeks it is best to begin the use of the limb very gradually, increasing it each day.—*The St. Louis Medical Review*.

THE USE OF A NEW OPIUM PREPARATION BEFORE ANESTHESIA.

A. M. Hellman, New York, states his objections to the use of morphine as shallow, insufficient respiration; inactive or absent corneal reflex; contracted, inactive pupil; abnormally slow pulse during anesthesia, and an occasional morphine collapse; no effect on post-operative vomiting, but afterwards, restlessness, constipation and lessening of secretions.

Pantopon, first introduced by Sahli in 1909, is an opium preparation containing the total alkaloids of opium in readily soluble form and suitable for hypodermic injection in sterile solution. The dose is from gr. 1-6 to gr. 1-3, hypodermically, and may be safely repeated. Hellman, in investigating its use in fifty cases, gave in each an injection of gr. 1-3, combined with atropin, gr. 1-100, as nearly three-quarters of an hour before operation as possible. This was difficult, for some patients received the injection too early because of postponement on account of previous operations, and others at the last moment, the effects in the first instances wearing off too soon, and in the last not manifesting themselves till near the end. Anesthetics used were ether and anesthol on an open mask.

Cases unaffected by the drug were, first, in which the patient was very alcoholic, and operation was started five minutes after injection; second, a bad phlegmon in an alcoholic, and in which

scopolamine and morphine were likewise ineffectual; third, an interrupted anesthesia for ulcer of the tongue.

The quantity of anesthetic was little for the length and nature of the operations and the method of administration. It could have been less had the anesthetizers realized how much they could depend on the pantopon when the patient was seemingly only superficially anesthetized. In 31 cases there was no vomiting; 11 vomited but once and slightly; 8, two or more times.

Comparing the drug with morphine, respiration was less shallow and never insufficient; the corneal reflex was not affected; the pupils were contracted, but never rendered entirely inactive; the pulse was steadied, and there was not a single case of collapse. Post-operative vomiting was lessened, and will probably be rare when it is understood that the quantity of anesthetic may be reduced. There was no noticeable constipation or diminution of secretions. Post-operatives narcotics were not required so soon as previously. In later cases, Hellman has left off the use of atropine.—*Virginia Medical Semi-Monthly*.

SUNLIGHT IN THE TREATMENT OF TUBERCULOSIS OF THE BONES AND JOINTS.

Professor Bardenheuer, of Cologne (*Deut. Ztschr. f. Chir.* Bd. 112, Hft. 1-3), writes encouraging of the value of sunlight in surgical tuberculosis. According to his observations in Rollier's sanatorium excellent results are to be obtained in cases of tuberculosis of the spine with fistulous tracts, while hip-joint disease is cured there by sunlight alone. Of Rollier's 369 cases of surgical tuberculosis, 77.3 per cent were cured, 13 per cent improved, 8.5 per cent remained unaffected, and 4 per cent died. Since his visit to this sanatorium Bardenheuer has employed this treatment at his clinic in Cologne in ten cases of tuberculosis of the joints without an external opening. The most striking results were obtained upon fistulas following joint resections which, even if of long standing, closed promptly.—*International Journal of Surg.*

OBSTETRICAL

OVARIAN CYST WITH TWISTED PEDICLE AND HEMORRHAGE INTO THE CYST, COMPLICATING PREGNANCY.

Dr. Herman J. Boldt reported the case of a woman, thirty-four years of age, who had had a child two and a half years ago. She was again pregnant four months. Six days previously she was seized with cramp-like pains in the left lower abdomen, and they had not entirely ceased. She asserted that since the beginning of her pregnancy she had had three such attacks, but the previous ones soon disappeared. The examination, soon after the beginning of the pain, was said to have revealed the presence of a small tumor about the size of a hen's egg. When the patient was examined by Dr. Boldt the tumor had markedly increased in size, the abdomen was sensitive to touch, and it was evident that a local peritonitis was present; this was shown subsequently upon operation by the presence of intestinal and omental adhesions. The diagnosis of an ovarian cyst with a twisted pedicle and hemorrhage into the cyst was based upon the sudden occurrence in the size of the tumor, the intraperitoneal position of the tumor, and its close relation to the uterus. Upon operation the diagnosis was verified. There were two twists of the pedicle.—*Medical Record*.

ECLAMPSIA WITHOUT CONVULSIONS OR UNCONSCIOUSNESS.

Schmidt (*Zeit. f. Geb. u. Gyn.*) says that the typical changes in the internal organs in eclampsia are degenerative processes in the parenchyma of the kidneys and especially in the epithelium of the tubules, with production of albumin and fat, and local degenerative necrosis; in the liver, hemorrhagic necrosis, with thrombosis of the capillaries and the inter and intralobular vessels; hemorrhage and softening in the brain, membranes, and central ganglia, with thrombosis of the small vessels; albuminous and fatty changes in the heart muscle and

hemorrhage and necrosis of these tissues. There are cases of puerperal poisoning in which convulsions and even coma are entirely absent, that still are cases of the kind of poisoning that causes the symptoms of eclampsia. He describes such a case with only slight albuminuria and swelling of the ankles, which died, and at autopsy showed these characteristic changes in liver, kidneys and brain. He also cites twenty-four cases similar to his own. There were premonitory symptoms of eclampsia, but these were not followed by convulsive seizures or coma. There were relatively often anomalies of the placenta necessitating interference. The prognosis for the child was better in the cases that recovered than in those which died. The author concludes that there is a characteristic pathological condition in eclampsia; when this is found postmortem we must conclude that the cause was one of eclampsia even when convulsions and unconsciousness are absent.—*Charlotte Medical Journal*.

CASE OF SALPINGITIS INFECTION FOLLOWING CONCEPTION.

Case presented by Dr. Morgan.—Dr. Morgan showed a case of a woman thirty-one years of age, married, with one child eleven years of age, and a history of several miscarriages. Her husband stated that she was exposed to gonorrhea, but she gave no history of inconvenience. Four weeks before admission to hospital she called her family physician, who found her in pain and bleeding. She said she had missed one period and was afraid she was going to miscarry. Bi-manual examination showed a mass posterior to the uterus, and a diagnosis was made of a probable ruptured ectopic pregnancy. When seen a little later there was a tremendous mass. On consultation she had been removed to the hospital and a laparotomy performed, and a pregnant uterus found. There was nothing to indicate a submucous or an intramural fibroid. Further examination brought to light a tubo-ovarian cyst on the right side and a chronic pyosalpingitis of the left tube with the fimbriated extremity closed. The tube and ovary on the right side were removed and the left tube also. Dr.

Morgan was amazed that the woman was pregnant. She began to menstruate after a rest of two weeks in bed. The interesting feature was that the woman became pregnant after an infection which apparently closed both tubes.—*The Medical Brief*.

GYNECOLOGICAL HINTS.

It is well to remember that sterility may be due to the husband, and therefore before any treatment is instituted a microscopic examination of the semen should be made to ascertain whether well-formed spermatozoa are present. In men who have had double orchitis from gonorrhea or mumps, you will frequently find that there are no spermatozoa, although in other particulars they may be in perfect health. Probably in not far from 5 per cent of cases sterility is due to the male.

In women, probably the most frequent causes of sterility are antelexion of the uterus, stenosis of the cervical canal, and salpingitis. In the first two conditions sterility is probably due to the resulting endometritis more than to mechanical obstruction. Drainage of the uterus, by thorough dilatation or appropriate operation, will frequently produce a cure.

Inversion of the uterus may be mistaken for a polypus projecting from the cervical canal. Before operating, a careful differential diagnosis should be made, for the removal of a polypus is usually a simple procedure, whereas if part of an inverted uterus is cut off by mistake, the woman will probably die in a very few minutes from internal hemorrhage due to wounding of the ovarian and possibly the uterine arteries. As soon as these vessels are divided they retract into the abdominal cavity and are very difficult to reach. This accident has happened a number of times.—*International Journal of Surgery*.

VOMITING OF PREGNANCY, TREATMENT OF.

Full observance of the hygiene of pregnancy is enjoined by the author in these cases. He recommends that the patient be given early in the morning a draught composed of magnesium

carbonate, 2 drams, magnesium sulphate, 1 ounce, mint water (1:40), 1 ounce; water, enough to make 8 ounces; a wineglassful to be taken early in the morning. *Cascara sagrada* is often prescribed, but must be considered only as a regulator of bowel action, not as a purgative. Laxatives should be given daily or every other day as required, and *cascara* given daily in small doses for about two or three weeks, after which no further medication of this kind will be required.

The diet should be free of rich or highly seasoned dishes. The evening meal should be light, and is usually best composed of some farinaceous article, such as thin porridge, gruel, or arrow-root. In patients obtaining no relief from sickness until the entire stomach contents have been evacuated, and when morning sickness is obstinate, it is well to encourage evacuation by the sipping of warm water. Absolute recumbency is necessary in severe cases. *Koumiss* is of value as a food, and may be utilized when nothing else is retained. Champagne half an hour before a meal is also beneficial.

In the matter of drugs, one finds it necessary to run the gamut of effervescing mixture, salicin in emulsion form, phenyl salicylate, compound tincture of cardamom in dram doses, antipyrin or acetanilide with sodium bromide, or even small enemata of chloral hydrate and potassium bromide. Cerium oxalate and cocaine are oftener useless than not. Landanum stupefies on the epigastrium, the ether spray, blistering of the cervical spine, or ice-bags applied to the same locality generally depend for their success purely on psychical effect. Wine of ipecac in hourly minim doses is unquestionably of use in some patients. The most efficient preparation is found by the author to be validol, whether the vomiting be reflex, neurotic, or toxemic. Menthol, 1 part in 60 of water, with 30 parts of alcohol or brandy, or chloroform (3 to 6 drops on sugar or in water), are sometimes useful, but are less certain in their results.

Rectal feeding has, according to the author, a psychic effect apart from its other influences, and gastric lavage acts somewhat similarly, though the latter undoubtedly is also beneficial because of the coincident hyperchlorhydria or intermittent hypersecretion.

Mental therapeutics, or antihysteroid treatment, is demanded in the purely neurotic type of vomiting. Massage, and possibly some little mystification in the shape of the application of electricity or blisters, etc., will help in the cure.

The toxemic variety of vomiting, when positively diagnosed, calls for the immediate procuring of abortion, a course never to be undertaken except after consultation with a brother practitioner.—*Monthly Cyclopaedia and Medical Bulletin*.

ECLAMPSIA, PUERPERAL, TREATMENT.

Combination of venesection with intravenous infusion of normal salt solution checked convulsions in 7 cases. Cleanse skin of arm, apply constricting band, expose median-basilic vein, and insert and tie in two thin-walled glass canulae, one pointing distally (for salt solution), other proximally. Bleed 10 to 15 ounces, stopping at first sign of weakened pulse, and introduce 1 to 2 quarts saline solution. This method indicated in many cases where convulsions appear after seven months of gestation and in all after eight months, in which other means do not relieve promptly and rapid delivery is for any reason impracticable. Plondke.—*Monthly Cyclopaedia and Medical Bulletin*.

MEDICAL

CHEMOTHERAPY.

As is well known, this term has become the familiar designation for that form of therapeutics which seeks to destroy living parasites in the tissues by the selective action of certain diffusible substances which are powerless to injure the tissues of the host. It is essential that the remedy shall act through the medium of the circulation. In all probability the great internal remedies, some of which have been in use for centuries, owe their power over acute diseases largely to the possession of chemo-therapeu-

tic properties. We refer here chiefly to quinine, mercury, iodine, salicylic acid, and arsenic, all of which have been used empirically. Atoxyl against a trypanosome disease was presumably the first rational application of this principle, the benefits being ascribed here to the arsenic component of the molecule. Salvarsan marked a great advance in the same direction. At a recent meeting of the Gesellschaft der Charite Aerzte, Berlin (*Berlinger klinische Wochenschrift*, January 15), Morgenroth read a paper on the subject which we are considering. The trypanosome furnishes a good test object of a chemotherapeutic research, as various chemical substances are able to attack it in the tissues, and synthetic derivatives of quinine, notably ethylhydrocuprein, have been tested on both trypanosome and malaria parasites, as well as on various pathogenic bacteria, especially in the pneumococcus infection of mice. More recently attempts have been made to form a synthetic which shall exhibit the power of salicylic acid over rheumatism, and thus far this property appears to be possessed in some degree by para- and metaoxybenzoic acids. The latter has all the force of salicylic acid with great reduction of its toxicity.—*Medical Record*.

ESOPHAGEAL CARCINOMA, HYDROGEN PEROXIDE IN.

When the descent of food is hindered in cancer of the esophagus, the author recommends that the patient sip small amounts of hydrogen peroxide solution of 1 to 2 per cent strength. A cleansing of the cancerous surface occurs which is sufficient to allow of easy passage of the food. Even in cases where rectal feeding has been found necessary this plan will often succeed. The peroxide should be sipped at intervals of an hour.—*Monthly Cyclopedia and Medical Bulletin*.

LUMBAR PUNCTURE.

The diagnostic value of lumbar puncture has been firmly established, but its therapeutic value is not so generally known. H.

Curshman always punctures with the patient lying on his side instead of sitting up, and introduces the needle laterally. For diagnostic purposes, 8 to 10cc. should be withdrawn; for therapeutic purposes enough to restore the normal pressure of 120 to 150 mm. water. Lumbar puncture is indicated in all cases of acute and chronic meningitis, meningismus and non-inflammatory increase of fluid. Really marvelous results are seen in the so-called serous meningitis, no matter whether the fluid is normal or contains more albumin with lymphocytes in the sediment. The condition is analogous to edema in other parts of the body and is often cured by a single puncture, though the patient's condition may appear very alarming. Meningitis due to influenza is often cured by puncture and the same may be said of meningeal inflammation following erysipelas, though streptococcus meningitis secondary to ear trouble is less favorably affected, and the epidemic type of the disease usually also requires the injection of serum. Irrigation of the spinal canal with sublimate solution has been recommended in cerebro-spinal syphilis. The results are least satisfactory in tuberculosis meningitis, though a few cases have been reported cured. Some brilliant results have been published in internal hemorrhagic pachymeningitis. Lumbar puncture has also been tried in a variety of other affections, such as gastric crises, chorea, epilepsy, tetanus, incontinence of urine, Meniere's disease, itching dermatoses, etc. The author could see no good effects in uremia, probably because the exudation is cortical and parenchymatous. The small operation is usually harmless, yet care is in place, particularly in nervous and hysterical patients. There is only one condition where lumbar puncture is serious and may be followed by sudden death, namely, in tumors of the posterior fossa. The high pressure will drop suddenly and the patient may become deeply cyanotic and cease to breathe, while the heart will continue to beat for some time. The tumor is usually in the cerebellum or in the neighborhood of the aqueduct and the fall of pressure resulting from lumbar puncture will force it against the foramen magnum or fourth ventricle. In rare cases, there may be hemorrhage into the tumor.—Therap. d. Gegenwart, June, 1911.—*The Medical Fortnightly*.

CHROMIUM SULPHATE IN CHRONIC PLUMBISM.

The past five or six months a case of chronic plumbism has been under my observation. The patient has for some years sought relief without avail. Even an appendectomy was done in the case under misconception of the cause of pain and colic. Being a printer and working with lead type there can be no mistake to assume that his pain and colic peculiar to lead poisoning are due to the saturnine metal. Wrist drop and a dark-bluish patch of lead sulphite on the lower gums substantiated the diagnosis.

The case gave me a great deal of concern. Being very enthusiastically recommended to him by a friend I was anxious to do something to make good. But how? That was the question. Everything had apparently been tried out in the routine of practice in these cases. I hardly felt grateful that my well-meaning but unsuspecting friend had so cordially urged this unfortunate man on to me. It appeared a thankless task.

The patient is but 35 years old, married and has a small family to support. He is proprietor of the printing shop making successful returns. He is loathe to abandon a well-paying business. So I advised him to do the outside work of soliciting trade and keeping away from the printing shop and its baneful influences, and leave the shop work to trustworthy help. Noticing, aside from this lead symptoms, that he was a very nervous subject, I happily thought of trying the use of chromium sulphate in the case. Now, after four months of its exhibition in the case I dare say that it is fair to report. This man has steadily improved under the faithful use of the chromium sulphate salt. His colicky spells of pain have become very much less frequent and decidedly milder under this treatment. The wrist drop is very markedly improved and his general nervous system very greatly restored. Thanks to the chromium sulphate; but only under its steady and faithful regularity of exhibition, as any laxity of the treatment soon tells. I watch this man with great interest and feel that by continuance of the faithful use of the chromium sulphate we may look ultimately for his complete recovery. The chemical nature of this drug must appeal to any one as a most likely efficient

agent against saturnism. So far, nothing has appeared in any medical literature, therefore, I call attention to this remarkable remedy in behalf of any case of lead poisoning in your hands. Try it out and let others hear the result.—*The St. Louis Medical Review*.

DRUGS WHICH DO SEXUAL HARM.

As strychnine may do great harm in paralysis, so it may do injury in sexual debility by irritating the already irritated erection and ejaculation centers. It causes their exhaustion and thus makes bad matters worse.

As to tobacco, I can not speak from personal knowledge. The statement is generally made that excessive use of tobacco causes sexual impotence. I have not seen such instances. I have seen excessive smokers who were impotent, but in them the excessive consumption of tobacco went hand in hand with the excessive consumption of alcohol, and it was impossible to decide which agent was more to blame. Morphine and cocain in small doses stimulate the sexual desire, but that chronic morphinists and cocainists are impotent is well known. The same is probably true of the habitual use of cannabis indica.

As to the injurious effects of the bromides, particularly potassium bromide, I have seen very sad cases. Some highminded young men considering extramarital intercourse morally wrong, decided to repress their sexual desires by the use of potassium bromide. At the advice of a young physician, they took 30 to 60 grains (2 to 4 grams) every night for a period of several months. Two of the young men kept up the bromide, with some intermissions, for over two years. They all succeeded in repressing, in suppressing their desires. But, unfortunately, they also succeeded in several other things: they succeeded in ruining their digestion, in getting a nice crop of bromide acne that was very resistant to treatment, and in becoming impotent.—*Practical Medicine*.

TWO CASES OF EXOPHTHALMIC GOITRE CURED
BY ORGANOOTHERAPY.

Regnault at the Societe de Therapeutique gave the history of two cases of exophthalmic goitre (*Bull. gener. de Therap.*, June 8, 1911, with typical symptoms that have been treated by ovotherapy. He had waited for several years before reporting them in order that it may not be said that the cures were only transitory. They had been treated by small doses of hematoethyrodine (which is a glycerinated product containing the total blood of an animal that has been deprived of its thyroid) and also dried ovarian powder. The reason for the treatment was that there seems to exist a functional antagonism between the internal secretions of the thyroid and the ovary, on the other hand, because of the etiology of the disease which, in these two cases first showed itself by cessation of menstruation. One case has remained cured for three years and the other for two.—*La Tribune Medicale*.

TREATMENT OF AFFECTIONS OF THE MAMMARY GLANDS DURING
LACTATION.

Dr. A. Schiller (*Wien. klin. Wochensch.*, No. 26, 1911), considers mastitis in nursing women as almost always due to stasis, caused by insufficient evacuation of the glands. The infection of the stagnant secretion is due to bacteria which under normal conditions vegetate in the lacteal ducts without giving rise to any mischief. If infection, as is commonly assumed, resulted from fissures we would more frequently observe cutaneous inflammation, plegmons or erysipelas of the integument of the breast. Although mastitis occurs quite often in breasts with fissured nipples, this does not, in Schiller's opinion, contradict his own views as to its origin. As regards treatment, he is especially impressed with the value of Bier's status hyperemia, which gives a prompt cure in the early stages and prevents suppuration. If pus has formed, nursing should be continued on the healthy as well as the affected side if the abscess is so situated that the nipple need not be bandaged. Large incisions and drainage are preferable to

punctures and hyperemia. As soon as possible after operation the child should be allowed to nurse on the affected side. As a rule, normal lactation is restored within a few weeks. With reference to the treatment of fissures at the nipples, Schiller recommends a naphthalin ointment, consisting of boric acid, 5.0, zinc oxid 10.0, naphthalin and lanolin, of each 25.0. Before every nursing the nipple should be cleansed with oil and cotton, some milk expressed, and the child then placed to the breast. After nursing is completed the salve should again be applied. As according to Schiller's plan nursing is allowed at intervals of four hours, one breast being given on each occasion, sufficient time is allowed for cicatrization in the affected breast. Even if the fissures are extremely painful anesthetic ointments are to be avoided, because they delay healing.—*The American Practitioner and News*.

DIAGNOSTIC IMPORTANCE OF HEMOPTYSIS.

W. B. Bartlett concludes from his study of the subject that bleeding from the upper air passages must be ruled out by careful inspection and history. Hemoptysis may occur in certain constitutional or blood diseases as merely another manifestation of the general tendency to bleed. Hemoptysis frequently occurs in broken compensation in heart disease and may occur in mitral stenosis as the only symptom of failing compensation. In such cases tuberculosis is frequently suspected; it is, however, rarely found. Ninety per cent of all hemoptyses are due to pulmonary tuberculosis. As a rule definite signs and symptoms do not develop for months or even years. Hemoptysis may occur in any ulcerating or eroding pulmonary disease. It should, therefore, be expected in abscess, gangrene, bronchiectasis, or pulmonary cirrhosis. In such cases careful study of the signs and symptoms and frequent examinations of the sputum will usually suffice to rule out tuberculosis. Hemoptysis in pneumonia, bronchitis, asthma or following trauma should lead to the suspicion of an underlying tuberculous process. It is very doubtful if

vicarious menstruation of hysteria can produce hemoptysis in normal lungs. Hemoptysis occurring without warning in young and healthy adults and passing off without the development of further signs or symptoms of tuberculosis is probably of tuberculous origin and should be so treated. Bronchopulmonary hemorrhage without definite symptoms or signs of cardiac or ulcerative pulmonary disease is due in nearly every instance to tuberculous infection, which is merely another way of saying that hemoptysis should be considered as due to pulmonary tuberculosis unless proved to be due to some other cause—*Medical Record*.

SMALL DOSES OF THYMOL FOR HOOKWORM.

In extra severe cases of hookworm infection, with a patient in much weakened condition, Stiles has found that the usual method of giving thymol may be modified to some extent. Instead of giving a preliminary dose of magnesium sulphate, none is given, and, depending on the condition of the patient, a small dose (10 gr. or somewhat more) of thymol is given and this is repeated one or two or three times at intervals, the patient in the meantime gaining strength. Some of the hookworms are thus eliminated, and when the patient has gained sufficient strength, if necessary, the usual routine is carried out and the full dose given. By this method the element of safety for the patient is increased to the maximum by treating along very conservative lines. (Public Health Reports.)—*The Journal of the American Medical Association*.

THE SERIOUSNESS OF MEASLES.

Physicians in this and other countries are beginning to regard measles in its true light, that of a disease serious in its menace to health and life. Reports recently of the death rate from measles have revealed the fact that it is by no means a disease to be treated lightly. When it attacks adults it generally leaves in its

wake a train of dangerous sequelae. Sir John F. H. Broadbent, writing in the *Practitioner* for October, draws attention to the lack of wisdom shown by medical men in Great Britain in allowing the old belief that measles was a trifling complaint to be perpetuated. It seems that it is not even a notifiable disease in London, and few, if any measures are taken to hinder the spread of infection. That it is acutely infectious in the catarrhal stage is well known, but on account of the ignorance of parents it is seldom that attempts are made to carry into effect the lesson to be learned from this fact. Dr. Sykes, medical officer of health for St. Pancras, goes so far as to recommend that inasmuch as the mortality from measles is mainly among children under five years of age, and infection is spread chiefly through the convergence of a large number of children to different centers, such as schools, all children under five years of age should be permanently excluded from the elementary schools. The great mortality that not infrequently accompanies an epidemic of measles, for example the mortality in the recent epidemic in London, is invariably due to neglect of precautions in the early stages of the disease.—*Medical Record*.

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at \$1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

OUR PREMIUMS.

With the last issue of the Journal, we offered a handsome premium of a clinical thermometer to every new subscriber, and to all the old subscribers who would pay the arrears on their subscriptions. In response to this offer a great many new subscriptions have been sent in and the mailing list of the Journal has been materially increased. The supply of thermometers has not as yet been entirely exhausted and we will take pleasure in mailing a thermometer to any one who sends in his name as a subscriber with the subscription price of the Journal (\$1.00) and to any old subscriber who will remit for past dues. As an additional inducement to those in arrears we will give one year's subscription from date on receipt of remittance for past dues, besides the thermometer.

In this number we publish, as may be seen from the announcement in the advertising form, an attractive clubbing rate with *Successful Medicine*, an excellent publication treating of the business side of physicians, edited by Dr. Henry R. Harrower, of Chicago. For one year's subscription to the Journal (\$1.00), or for old subscribers who will remit what is due for past subscriptions, we will send for one year the *Nashville Journal of Medicine and Surgery*, *Successful Medicine* for the same length of time, and an excellent clinical thermometer. Surely this is an attractive offer, and the profession should not be slow to take

advantage of it. Names should be sent in promptly and without delay. Do not put this off, but write a check for \$1.00 or get a P. O. order or registered letter for this amount and mail to the Journal's address. It is but very little trouble, it is a small amount, and any one who takes advantage of the liberal offer will get for \$1.00 one year's subscription to the Journal, one year's subscription to *Successful Medicine* and a handsome certified clinical thermometer in case with chain.

DR. T. D. CROTHERS.

Our readers will be interested in the paper by this eminent writer which appears in this issue of the Journal. Dr. Crothers is widely known for his many valuable papers on inebriety and kindred subjects which have appeared from time to time in medical journals. Our thanks are also due Dr. Crothers for a complimentary copy of the Transactions of the National Medico-Legal Society of which body he is the honored president, and which contains his most admirable address as president of the body. We hope in the future to have more contributions from this distinguished writer.

FACING A JURY.

The uncertainty of a jury's findings was illustrated recently at Indianapolis. A young woman brought suit against a druggist, alleging that when she had a prescription refilled oil of tar was substituted for liquid tar. This resulted in a burn of the face, caused her eyes to swell and to lose her eyebrows and otherwise to injure her. It had been suggested that oil of tar had been substituted for liquid tar, though no testimony was offered to support this allegation by an expert or anyone else; nor was any analysis of the refill made. The drug clerk testified that there had been no substitution. Drs. A. W. Brayton, Professor of Dermatology; S. E. Earp, Professor of Clinical Medicine, and W. H. Foreman, Professor of Therapeutics, formerly Professor of Chemistry in the Indiana University School of Medicine, testi-

fied strongly in favor of the defendant, each one having used the prescription with and without the alleged substitute, both upon their own persons and on that of others. Dr. T. Victor Keene, a member of the Indianapolis Board of Health, expert, also testified for the defense. No testimony in rebuttal was offered, depending entirely on the testimony of the young woman. The plaintiff did not even call the physician who treated her, yet the intelligent jury gave the young woman \$150.00 damages.—*E. S. McK.*

DEATH OF THE OLDEST MAN IN TENNESSEE.

The morning papers announce the death of probably the oldest man in the State of Tennessee—Antonio Gotto—a resident of Davidson County, at the age of 103 years. He died at his home near Una, Tenn., March 13. He was certainly a remarkable man, as he was known to walk frequently to Nashville, a distance of over six miles, after he had passed the century mark.

Several to whom we have sent thermometers have written that the thermometers were received broken, although they had been mailed in strong wooden boxes made for shipping. Of course we sent duplicates at once, and will be glad to hear of any other such mishaps.

BACTERIOLOGIST (MALE). Philippine Service. April 6, 1912.

The United States Civil Service Commission announces an examination to secure eligibles from which to make certification to fill a vacancy in the position of research in the biological laboratory of the Bureau of Science, Manila, Philippine Island, at a salary of \$2,500 a year, and vacancies requiring similar qualifications as they may occur in the Philippine Service, unless it is found to be in the interest of the service to fill the vacancy by reinstatement, transfer, or promotion.

It will not be necessary for applicants to appear at any place for examination. Their eligibility will be determined upon the evidence furnished in connection with application and examination Form B, I, A, 2, concerning their training and the work which they have accomplished.

Applicants may, if they desire, submit with their applications copies of theses or publications which have been prepared by them.

This position is for a research bacteriologist with clinical experience, and applicants must be graduates in medicine; in addition they must show that they have specialized extensively in bacteriology and are capable of doing original research work. The ordinary bacteriological training incident to a medical course or a hospital internship will not be considered in this connection.

All statements relating to training, experience, and fitness are subject to verification.

Applicants must be willing to enter into a contract requiring at least two years' residence in the Philippine Islands.

The work comprises investigations in tropical medicine in conjunction with the chief of the biological laboratory, who is also professor of tropical medicine in the College of Medicine and Surgery. The clinical material of the Philippine General Hospital and the hospital of the Government prison will be available for study in connection with bacteriological investigation. It is stated by the Bureau of Science that opportunities exist for promotion to higher places as vacancies occur, and at present there are six positions in this laboratory above the one in question, at salaries ranging from \$2,500 to \$5,000. The library of the Bureau of Science and the equipment are of the very best and strictly modern, so that this position offers a unique opportunity for a young man who is ambitious and who desires to make a name in research work in this specialty.

Age limit, 18 to 40 years on the date of the examination.

The medical certificate on Form 2 must be filled in by some officer in the service of the United States. Applicants should appear before medical officers of the Army, Navy, Indian, or Public Health and Marine-Hospital services. If such an officer can not be conveniently visited, a pension-examining surgeon may exe-

cute the certificate. Special arrangements have been made with pension-examining boards throughout the country to give such examination for a fee of \$2, to be paid by the applicant. This certificate must not be executed by the family physician of the applicant. The medical officer should indicate his rank or official designation on such certificate. When it is impracticable, by reason of the applicant's distance from a Government physician or a pension-examining surgeon, to have the medical certificate executed by such physician, it may be executed by any reputable physician. Such person may be required to undergo another examination in case of appointment.

Each applicant will be required to submit with his application a photograph of himself, taken within three years, which will be filed with his papers as a means of identification in case he receives appointment. An unmounted photograph is preferred. The name and date of examination, the competitor's name, and the year in which the photograph was taken should be indicated on the photograph.

This examination is open to all citizens of the United States who comply with the requirements.

This announcement contains all information which is communicated to applicants regarding the scope of the examination, the vacancy or vacancies to be filled, and the qualifications required.

Special attention is invited to the favorable conditions in respect to transportation, leave of absence, clothing, etc., in this service printed hereon.

Applicants should at once apply for Form B. I. A. 2 to the United States Civil Service Commission, Washington, D. C., to the secretary of the board of examiners, postoffice, Boston, Mass., Philadelphia, Pa., Atlanta, Ga., Cincinnati, Ohio, Chicago, Ill., St. Paul, Minn., Seattle, Wash., San Francisco, Cal.; customhouse, New York, N. Y., New Orleans, La., Honolulu, Hawaii; old customhouse, St. Louis, Mo.; or to the chairman of the Porto Rican Civil Service Commission, San Juan, P. R. No application will be accepted unless properly executed, including the medical certificate, and filed with the Commissioner at Washington prior to the hour of closing on April 6, 1912. In applying for

this examination the exact title as given at the head of this announcement should be used in the application.

Issued March 6, 1912.

N. A. R. D. NOTES.

Attention is called to notes of the National Association of Retail Druggists, which appears for the first time in this issue of the Journal. This establishes a new and important department for this publication, and we hope that these notes will appear regularly hereafter under the editorship of a local pharmacist, whom we shall appoint later. The importance of these notes is manifest, as they serve to acquaint physicians with properties and formulas of preparations in common use in the practice of medicine.

We call the attention of our readers to the excellent article appearing in this issue translated from the German by Dr. Howard S. Jeck of this city. The work of translation has been excellently done, and the subject of which it treats of the greatest interest to the profession. We hope that this paper will be followed by others from the facile pen of our talented young friend.

The electroplate of *Successful Magazine* has not yet been received, so that it will not appear in this number of the Journal. The proposition still holds: For \$1.00—one year's subscription to *Nashville Journal of Medicine and Surgery*—one year's subscription to *Successful Medicine*, and a clinical thermometer. Fill out coupon or application blank and take advantage of this liberal offer.

Reviews and Book Notices

Pellagra.—By George M. Niles, M.D., Professor of Gastro-enterology and Therapeutics in the Atlanta School of Medicine, Atlanta, Ga. Octavo of 253 pages. Illustrated. Philadelphia and London. W. B. Saunders Company. 1912. Cloth, \$3.00 net. W. B. Saunders Co., Philadelphia. London.

Our thanks are due the enterprising publisher for a copy of this timely work. It is a treatise upon an old disease in which from its alarmingly increasing prevalence of late years in this country, especially in the Southern section of the United States, the profession has displayed the greatest interest and activity. The author in the work he has presented on this subject has made a most exhaustive exposition of the disease so that the practitioner who desires to post himself on the disease in all its phases can do so without having to delve in a mass of scattered literature in order to do so. The etiologic and pathologic features of pellagra though still unsolved problems are discussed from every standpoint. The symptomatology is given carefully and exhaustively, and the terminations and treatment thoroughly handled. As stated above, the work is decidedly timely in its appearance, and in view of the widespread prevalence of the disease, and, without reflection upon the profession of today, in view of the ignorance of physicians as to the symptomatology and the course of the disease, we consider the book a most valuable addition to present day medical literature. We feel sure the profession will eagerly welcome the work and equally sure that it will prove of the greatest value in the hands of the physician. We have read the work carefully through and recognize fully the merits of the book. We do not hesitate to recommend it to our readers and urge them to supply themselves with a copy.

Blakiston's Quiz Compend?—A Compend of Genito-Urinary Diseases and Syphilis, Including Their Surgery and Treatment, by Charles S. Hirsch, M.D., Formerly Assistant in the Genito-Urinary Surgical Department, Jefferson Medical College Hospital; Consulting Physician,

Social Service Hospital and Juvenile Protection Association, Philadelphia, with 74 Illustrations. Philadelphia. P. Blakiston's Son & Co., 1012 Walnut Street. 1912.

The second edition of this excellent number of Quiz compend series is before us. We are immensely pleased with it and think it possesses unequalled advantages for presenting in condensed form the subject matter to the student and practitioner. It certainly is the best of its class and ought to become popular with the profession. The second edition has been thoroughly revised and brought fully up with the most recent advances in this department. We have been especially pleased with the chapter on Syphilis, in which the author presents in the most lucid manner the serum diagnosis of syphilis, giving in detail the principles and technic of the Wasserman and Noguchi tests. This chapter of itself makes it of exceptional value as a work of reference for the practitioner. The treatment of syphilis by the salvarsan method is clearly and succinctly given in such a way as that it may serve as a guide to any one who desires to employ this new discovery. In our opinion this excellent compound should be recommended by teachers of Genito-Urinary Diseases over and above many of the more pretentious text-books upon the subject. The author is to be congratulated upon having given us such a perfect book of its class.

Thirty-eighth Annual Report of the Secretary of the State Board of Health of the State of Michigan for the Fiscal Year Ending June 30, 1910. By Authority Lansing, Michigan. Wynkoop-Hallenbeck-Crawford Co., State Printers. 1911.

This annual report of the Michigan State Board of Health is even more interesting than that of former volumes as showing the character of work done by this well organized and thoroughly efficient Board of Health. Sanitary measures are treated of in the most up-to-date manner, and the work is thoroughly illustrated whenever necessary. The statistics of communicable diseases are tabulated in such a manner as to make reference easy. The State of Michigan should be proud of the work of its Board of Health as demonstrated in this well arranged report.

Publisher's Department

"For some years there has been a tendency among the profession to use sodium salicylate to the practical exclusion of other agents in the treatment of acute articular rheumatism. Even the therapeutic nihilist has conceded to sodium salicylate the first place in rheumatism, as he accords it to quinine in malaria, or to anti-toxin in diphtheria."

"The recent reports by Menzer, a surgeon in the German army, tend to discredit the too implicit faith placed in the use of the salicylates alone in acute articular rheumatism. It is not denied that the salicylates pushed to effect will alleviate the symptoms, but he asserts that cases so treated are more subject to relapse and to permanent deformity than are those in which other remedies are exhibited, and that there should be incorporated with the salicylates other agents which will not encourage injurious complications."

In Tongaline, sodium salicylate from the natural oil is combined with tonga, colchicum, black cohosh and pilocarpin, whereby the organs of elimination are greatly stimulated, so that prompt and efficient results are secured without the necessity of such large doses of the salicylates as to secure any harmful effects.

Pepsin is undoubtedly one of the most valuable digestive agents of our Materia Medica, provided a good article is used. "Robinson's Lime Juice and Pepsin" (see page — this number) we can recommend as possessing merit of high order.

The fact that the manufacturers of this palatable preparation use the purest and best Pepsin, and that every lot made by them is carefully tested before offering for sale, is a guarantee to the physician that he will certainly obtain the good results he expects from Pepsin.

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NASHVILLE JOURNAL — OF — MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

VOL. CVI.

APRIL, 1912.

No. 4.

Original Communications

ON THE RADICAL REMOVAL OF THE CONDITIONS CAUSING ARTERIAL CHANGES LEADING TO NON-PSYCHOGENIC DISTURB- ANCES OF THE NERVOUS SYSTEM.—CASES.*

BY TOM A. WILLIAMS, M.B., C.M., EDIN, *Washington, D. C.*

I.—The "Neurasthenia" of Sclero-genetic Toxicosis, without very light blood pressure.

II.—Diagnosis of this state by Neurological Symptoms and Signs.

III.—Cases: (1) Focal Epilepsy from Arterial Changes; (2) Incipient Presenile Melancholia; (3) Metabolic Psychasthenia.

IV.—Diet Most Important Element of Successful Treatment.

Whether persistent high blood pressure is itself the cause of arteriosclerosis or whether it is only another effect of toxicosis which degenerates the arteries is still a problem.

We now know that sclerosis of the arteries occurs in some subjects without a marked rise of blood pressure (Councilman). It is in these cases that we have to rely upon other signs for a diagnosis, more especially when nephritis has not occurred. It is in the nervous system that these reveal themselves earliest; and it is unfortunate that sclero-genetic toxic states are so often overlooked by physicians on account of the facility with which

it has been the habit to label "neurasthenia" the varying symptoms in the causation of which circumscribed lesions of the nervous system can be excluded.

It needs to be reiterated that there is no nosological entity, neurasthenia, which is only rather a loose name for a clinical condition attributable to some definite cause or causes, generally intoxicative, such as hypo or hyperthyroidism, deficiency of the adrenals, incipient Bright's disease, disturbances of the digestive organs, tuberculosis, syphilis, pellagra or other chronic infections, animal parasites, a poor, badly balanced or excessive diet, or the imbibing of exogenous toxins; and, lastly, mental worry and unhappiness, which act indirectly by perverting metabolism and thus producing the toxicosis which determines neurasthenia.

It is the doctor's business to find out the causes in each case and to remedy them. In searching for these, the general practitioner may require the aid of specialists. This is particularly so where the nervous system is affected; for I am sorry to say that neurological technic has been acquired up to the present by very few of the busy men who pursue general or special practice. In illustration of these statements, are reported the following cases, where the gravity of the symptoms led to an early consultation, which enabled proper treatment to be instituted in time, so that good health was quickly restored.

Case I.—A man of 64, chief architect in the Indian Service, consulted me February 10, 1910, having been sent by Dr. Phillip Roy because of the recent occurrence of epileptiform convulsions with loss of consciousness.

The first attack had occurred in May, 1909, at an elevation of twelve thousand feet, near Durango, while he was inspecting the school buildings there. He was unconscious for half an hour. The second attack occurred shortly after, upon leaving the train in Chicago, while making for the staircase. It lasted about an hour. A third attack took place that July in his office, lasting one and a half hours. The fourth and last had occurred two nights before his visit to me, while he was visiting a friend and sitting down. It lasted three hours.

The attacks are preceded by a creeping sensation in the left upper arm, passing slowly down to the hand, which becomes numb. In about fifteen minutes, unconsciousness supervenes. The face is said to be flushed; that he is uncertain whether there are convulsions, though others have told him that there are. The duration of the attacks was only surmised.

Previous History.—Had scarlet fever at six without bad sequelae. An active, healthy man, except for two years of asthma twenty-five years before, a result of constant attacks of catarrh. It was cured by working as a farm-hand for three weeks. He smokes two cigars and a pipe a day. He took coffee and was a heavy drinker until after the attack; now he has ceased to even take tea. He has always been abstemious in eating; but has been fond of salty foods. He drank "when he felt like it." Since these attacks, he has had a pain over the forehead when coryza occurred. As he had read that insanity might come on from this catarrh, he was at first a little anxious about his state, but soon steeled himself against it.

The pain in the head was rather a feeling of depression and a grumbling pain like that of catarrh. The discharge was slight, and the headache disappeared when the attack ceased. He used to sleep quite well, but about the time of his attacks, he began waking in the early morning, and could not fall asleep again. This persisted.

He had been recommended to eat more, and to take fat meat, and this he had done.

Physical Examination.—*Reflexes:* Knee kick, right greater than left; Achilles reflex, right less than left; triceps, left greater than right.

Radials equal. None markedly exaggerated. Plantar reflex is normal. The left cremaster is absent.

Sensibility.—No abnormality in lower limbs to pain, touch, temperature, nor attitudes, though the latter are sometimes wrongly named, but correctly recognized.

Arms.—Perfect localization of light touches, both segmentally and axially. Spacing sense of fingers normal. Other modalities

normal except sense of attitudes poor, especially in the left hand. No hemiopia or colour inversion of visual fields.

Motility.—Normal, but left fingers weaker than right. Diocokinesis regular. Pupils contract promptly.

Psychic Functions.—He thinks his memory is weakened since the attacks. There are no disorders of speech. Emotionally, he has always been easily excited when there was a cause, and has been accustommed to occasional sadness.

Diagnosis.—The localization of the aura in the left arm and hand, along with the increase of the triceps reflex and the loss of the cremasteric, point to an organic perturbation of the sensori motor area of the right hemisphere, probably mainly in or near the cortex of the central fissure, opposite the second frontal convolution. The cremaster-governing fibers are, of course, attacked in some other situation.

As neoplasm and granuloma were each unlikely, and as the man's age is that of arteriosclerosis, of the state preceding which the recently acquired matutinal insomnia was indicative, I believed it wise, although lacking proof, to adopt the supposition of sclerogenetic toxicosis, and to put it to the experimental proof of therapeutics.

Accordingly, a diet light in proteins was ordered, and coffee and tobacco were forbidden. The result was confirmation, as the patient, one year from the consultation, remains free from attacks and insomnia, and is perfectly well able to perform his very strenuous work, often in high altitudes.

I believe that the first attack was inaugurated in consequence of an ischæmia of a part of the right Rolandic region, due to the heart, strained by the high altitude, not being able to keep full of blood a partially sclerosed vessel distributed to that area. The second attack was likewise due to a sudden demand upon the heart upon leaving the train after a very hot journey.

Case 2.—Physician aged 68, referred to me by Dr. Balloch because of a "nervous breakdown." For over a year, he had been worrying over the death of his son and the serious illness of his wife and daughter. He was suffering from severe in-

somnia, tinnitus aurium, and numbness and tingling in the toes of the left foot and in the hand; sometimes less markedly in the right. He sometimes lost the ability to distinguish one from two pins between thumb and fingers. His power of endurance and sight and hearing had markedly diminished, and his former optimism had changed into an incapacity for enjoyment. All the organs were normal, but he had lost about twelve pounds, although the appetite was fairly good. He believed that he was not physically ill.

On questioning it was found that he had slept badly for about five years, waking in the early morning, unless he took diethyl-malonylurea, of which he used five grains every fourth night. On waking, sad thoughts of his son's death and daughter's troubles made him weep.

Physical Examination.—Reflexes rather active. Motor functions and diadokokinesis well performed. Sensibility normal. Heart normal. Pulse slow and regular. Blood-pressure 187 mm. Hg. Liver rather small. The paresthesiae disappear when the parts are stretched, and occur only when he worries.

Diagnosis.—Sclerogenetic toxicosis was diagnosed from the raised pressure, the nature of the insomnia, the paresthesia without sensory defect, and the loss of endurance.

Treatment.—A low purin and protein diet was prescribed, and hypnotics were forbidden. In a few days he began to feel better, and now, nearly two years later, he remains quite well. He had been taking a popular aromatic caffeine beverage, and this was stopped as soon as I learned of it.

It is not only in the aged that the presclerotic syndrome with nervous disturbances occurs and can be removed by means of a diet low in nitrogen in purin.

Case 3.—Metabolic Psychasthenia. An engineer of 38, referred by Dr. Atkinson, powerful, energetic man, formerly accustomed to active work, began to be unable to concentrate upon the office work, to which he had confined himself for over three months. Previous to this, he had been much less active; and latterly, he had been very much worried by an official inquiry

into a contract for which he had been mainly responsible. For no cause known to him, he feels a dread in the mornings, and an indecision in business matters is now realized to have been present several months. There was no syphilis nor any other organic disease.

He had been improved by three weeks in the woods, during which he was very somnolent, but relapsed at once upon return, and could hardly stand his morning suffering. There was no insomnia.

Physical Examination.—The reflexes were rather active; but there was no objective change in the lower neurones; there was no amnesia; the sexual hygiene was normal. He was much depressed, and longed to go away from it all for a year, which he could well afford to do.

Treatment.—He was sent for three weeks into the mountains. This time he fully recovered on account of the light diet which he took. Breakfast and supper were fruit and milk, and his mid-day dinner was vegetables and six ounces of meat; after a few days, cereals were added morning and night.

As prevention excels cure, such results are better than that obtained by removal of effects by baths, electricity or chemical eliminants (diuretics, sudorifics, purgatives), or antagonists (iodides, nitrates), or still worse, narcotics, hypnotics or calmatives, which only mask the disease while it progresses.

THE DIET IN ARTERIO-SCLEROSIS AND NEURASTHENIA OF THE CLIMACTERIC.

To prevent the formation of toxins is both easier and more effective than to eliminate them when formed; although, of course, this can be done by stimulating the emunctories of the skin by baths, of the bowels by purgatives, or of the kidneys by diuretics, or of the lungs by active exercise, or of the whole organism by electricity. The supposition of the effects of toxins by counteracting substances, such as the nitrites or iodides is still less desirable; and no condemnation is too great for the masking of the warning symptoms by means of sedatives, such

as bromides or hypnotics, and narcotics, such as chloral, morphine, alcohol or the synthetic drugs.

Another measure to be reprehended is the whipping up of the body reactions by means of the strychnine or caffeine groups of alkaloids.

As the patient's ill health is due to his inability to metabolize the excess of protein which he had formerly taken with relative impunity, the indication is to see that he takes only the physiological amount, which for a person past midlife should not exceed fifty grams per day. At the same time, calorics must not be deficient. In the third place, the vegetable salts must be supplied in sufficient amount for free secretory and excretory activity.

I give a sketch of a diet, which of course must be varied to individual cases.

While dressing, five to ten ounces of hot water containing ten to twenty grains of either sodium sulphate, potassium citrate, sodium phosphate or similar alkaline saline, according to the nature of the case. Half an hour later breakfast of a *large* plate of fruit and milk or cream, followed by abundant cereal and milk, with bread and butter. No meat, eggs or fish. Wait five hours. Dinner. Not more than four ounces of meat or fish, which must be quite fresh, a *very large* plate of green vegetables; potatoes sparingly, and preferably nothing more than perhaps a taste of sweets. The evening meal, five hours later, may be a repetition of the breakfast; but for it succulent vegetables may replace the fruit, and macaroni or a similar dish may be substituted for the cereal. Thirst and hunger between whiles may be satisfied by water and fruit about one hour before a meal or during the night. The purins are avoided; so that meat juices are abstained from; and soup, which may be taken at dinner or supper, must be made entirely of vegetable food. Alcohol is forbidden, even as beer or wine. Tea, coffee, cocoa and kola must be abstained from; as, besides being closely allied to the xanthins bodies, they are toxic to the nervous and circulatory systems.

Gradually this diet is added to, an occasional egg being given at breakfast or supper; and the patient very soon learns what suits him best. Some culinary ingenuity is needed to give variety to a diet which at first appears monotonous. In this respect, the tastiness of well prepared whole wheat bread is a great gain.

Gentle and regular *exercise* twice daily is a great aid to healthy metabolism; and proper calmative *baths* are most beneficial. Of course, proper *psychotherapy* to allay the patient's alarm is of great importance; besides which it teaches him the real status of his health, and provides him with the means of counteracting his mental depression by the knowledge that it has a physical source, and will pass away as this improves. Sometimes, the morbid depressive ideas are somewhat fixed; and they must then be met by frequent rational persuasion to readjust the patient's point of view. The effect of a change of environment is often only temporary, unless it is not made merely empirically. If it is made part of a psychological reconstruction and guided by the physician, it should, however, help rather than hinder the resumption of work, even in an unsatisfactory environment.

1758 K Street.

TWO STANDARD, OFFICIAL THERAPEUTIC REMEDIES.

N. A. R. D. NOTES.

The following two official preparations have much to recommend them. They are here commented upon at this time because they are seasonable and because they are worthy the confidence of every physician. They are meritorious products and as made by the capable pharmacist, have a maximum of therapeutic efficiency.

TINCTURA VIBURNI OPULI COMPOSITA, N. F.

The Compound Tincture of Viburnum represents in each 4 Cc. (1 fluidram) dose, the following: 2 grains each of Viburnum Opulus and Dioscorea, $\frac{1}{2}$ grain of Scullcap, 3 grains of

Cloves and 4 grains of Cinnamon. It contains about 85 per cent of Alcohol and $6\frac{1}{2}$ per cent of Glycerin.

One of the chief functions of this combination is to quiet the movement of the uterus and to lessen the uterine flow. There is abundant testimony at hand to confirm the value of *Viburnum* in threatened abortion. Dr. Phares, of Mississippi, as early as 1866, ascribed to it valuable nervine, antispasmodic and tonic properties in the above conditions, and the present formula for the compound tincture yields what is possibly a most active and reliable therapeutic agent for these conditions.

It may at times be necessary to increase the amount of *Viburnum* in the preparation, and this is readily accomplished by the addition of the fluid extract. It sometimes causes nausea and vomiting, and in such cases, some other remedy must be substituted. It is best administered in hot water, preferably sweetened.

There are many proprietary "viburnum" compounds on the market under various fanciful names, and of somewhat similar composition to the above, but it is well to guard against their usage for several reasons. One is that their composition is an unknown quantity, and another is that the "original" package is as a rule accompanied by literature the reading of which is a natural and very prolific cause of self-medication on the part of the laity.

TINCTURA BELLADONNAE FOLIORUM, U. S. P.

Tincture of Belladonna leaves is an assayed tincture of definite strength representing ten per cent of Belladonna leaves in a menstruum of Diluted Alcohol. While it contains a definite percentage of alkaloids (.0003 per cent or 1 grain in 7 3-10 fluid-ounces), we would respectfully caution physicians that these alkaloids do not always represent the total value of Belladonna leaves as a medicinal agent. The natural combinations of the alkaloids with other principles as they exist in the leaf should always be reckoned with. However, these alkaloids, and especially Atropine, have their specific uses in medicine.

The pharmacological action of Belladonna is varied, thus indicating a very wide sphere of usefulness. It is employed in direct conformity with its pharmacological action, as follows:

Medicinal doses quicken the pulse and raise the arterial pressure; small doses increase peristalsis by paralyzing the inhibitory fibres of the splanchnic. It lessens all secretions except those of the kidneys and intestines.

This tincture is the best and most widely used preparation of Belladonna. This drug is one of the most valuable agents in the materia medica, ranking high in efficiency and its wide range of usefulness. The dose range is from 0.3 to 1.2 Cc. (5 to 20 minims).

Proceedings of Societies

CINCINNATI ACADEMY OF MEDICINE.

MEETING OF FEBRUARY 25, 1912.

Dr. A. G. Drury, as chairman of the committee, read a short eulogistic history of the life and accomplishments of Dr. Thos. C. Minor, with resolutions on the death of Dr. Minor, which were adopted. Dr. Francis W. Dowling gave a short impromptu address on some personal characteristics and incidents in Dr. T. C. Minor's life.

On motion by Dr. Charles Caldwell and amended by Dr. Drury, the regular meeting night of March 11, 1912, was voted as a memorial meeting to Dr. A. B. Isham. This is to be the regular order of business for the evening.

The committee appointed to investigate the Medical Reform Institute, Inc., 1425-27 Vine Street, reported:

1. That the Medical Reform Institute is not incorporated, and cannot be incorporated under the laws of the State of Ohio. One of the forbidden purposes of an incorporation is the "conduct of professional business."

2. This concern is running essentially a medical service brokerage business, acting as middleman between patient and doctor, which your committee believes to be detrimental to the welfare of both the public and the medical profession.

3. This institute is particularly vicious in that it advertises as blatantly as the worst quack, and at the same time uses the names of reputable physicians to bolster up its business.

4. Your committee finds that many reputable physicians, and some of them members of the Academy, have permitted the use of their names without a full knowledge of existing conditions, and will no doubt withdraw all connection with the concern and forbid further use of their names, upon being properly informed.

5. Your committee recommends that evidence of services hereafter rendered by members of the Academy of Medicine for the Medical Reform Institute be submitted to the Board of Censors for action.

We wish to thank Mr. Paul Rover, attorney, for signal services rendered both here and in Columbus in this matter.

Respectfully submitted,

G. STROHBACH,

ROBERT W. THOMAS, *Secretary*.

CASE REPORTS.

Dr. J. A. Thompson reported a case, and presented the patient, with acute suppurative themoiditis with orbital cellulitis, Discussed by Dr. Charles Caldwell.

Dr. Jos. Ransohoff presented a patient with fracture of the femur, with several X-ray plates to show original deformity, and result of his unique and original method of treatment. Patient had two and a half inches of shortening, and to get proper amount of traction Dr. Ransohoff used a pair of ice tongs to grasp the lower end of the femur, so as not to require plaster, use a nail through the os calcis, or Buck's extension, or do an open operation of Lane, using the bone plates. Ice tongs were applied just above the knee joint, and it required forty pounds weight to correct the deformity. Result of continuous extension was productive of a good result anatomically and functionally. Patient had little or no shortening and good motion of the knee. Dr. Ransohoff said that only a limited number of fractures should be treated by the open method, and then only by a thoroughly competent surgeon who was sure of his surroundings and technique; that bones situated deep were less favorable cases for bone plates than the more superficial ones. Dr. Charles Caldwell said that in his judgment the femur and deep-seated bones were quite as desirable risk for plating as the more superficial ones, and that infection was not always carried in, but might be due to cryptogenic type of infection from some focus of infection in a remote part of the body.

Dr. W. D. Haines agreed in the main with the ground taken by Dr. Ransohoff, and was conservative in his advice to use Lane's bone plates. A functional result was desired more than an anatomical one. Dr. Ricketts reviewed briefly the history of the open operations for fracture, and congratulated Dr. Ransohoff on his ingenious method of procedure in this case, and on the results he obtained. When men of Ransohoff's experience were conservative on these lines, it is well to select our cases very carefully. Dr. Ransohoff, in closing, asked if any one present had ever seen a simple fracture suppurate when treated by the closed method and ventured the statement that cryptogenetic infection did not occur once in five hundred cases.

Dr. B. M. Ricketts presented a specimen of ovarian hematoma, and held that these cases were less rare in his experience than found by most authorities. He also presented the specimen of a case of primary tuberculosis of the index finger, for which he did an amputation.

Dr. M. L. Heidingsfeld reported two cases: (1) Elephantiasis cutis penis, of twelve years' duration, and so extensive as to prevent the sexual act. The elephantiasis was due to extensive bilateral excision of the inguinal glands twelve years ago, for suppurative bubo from chancroid. (2) A case of extensive vegetating papular syphilides, in women where there was some tendency to lymph edema of the labia. He stated that this class of cases would respond more favorably to salvarsan than any other form of treatment. Both cases were illustrated with colored lantern slides. Discussed by Dr. A. W. Nelson, who said that ordinarily incision and drainage was sufficient in these cases, and only rarely was excision demanded. Drainage with cleanliness and antiseptic treatment was his practice.

Dr. M. A. Brown reported in detail two cases of cerebrospinal meningitis, type meningococcus intracellularis. One was treated with New York Health Board serum and the other with serum from a pharmaceutical house. Both recovered. Discussed by Drs. Frank Lamb and Ed Baehr. Dr. Baehr contended it was a surgical proposition largely, and that drainage and withdrawal of the purulent exudate from the cord was the keynote

in treatment. He agreed with Dr. Brown that washing out the canal was advisable. Laminectomy and temporary drainage in these cases was a justifiable procedure, and that as much or more benefit came from washing and drainage and salt solution as from the serum. He believed the condition was analogous to an empyema. Dr. R. W. Thomas called attention to the fact that these cases sometimes follow epidemics of influenza, and that as a prophylactic measure the nose, throat and accessory sinuses should have proper care and antiseptic cleaning. Dr. Brown, in closing, said that drainage did not cure the cases before the serum was discovered and used. Undoubtedly the relief of pressure by withdrawal of cerebro-spinal fluid was beneficial. He would not hesitate to wash out the cerebro-spinal space with saline, and rather favored giving larger doses of serum, even up to 40 to 60 cc. Pressure and cerebro-spinal fluid tend to recur from time to time when serum is not used. The colored race seems to be more susceptible to the disease than the white race.

MEETING OF MARCH 4, 1912.

The Secretary read a communication from the Business Men's Club, relative to national legislation on commercial use of phosphorus. The communication asked that the Academy take such action and recommend such legislation as will best protect the health of the laborers. This matter came primarily from organized labor, and was referred to the Academy by the Business Men's Club of Cincinnati. On motion of Dr. Schenck, the matter was referred to the Standing Committee on Legislation, Dr. J. C. Oliver, Chairman.

The regular paper of the evening was then read: "The Cystoscope as an Aid in Urinary Diagnosis and Treatment," by Dr. A. W. Nelson. Dr. Nelson reviewed the history of the instrument, and said efforts at its use were made as early as 1807, and showed a number of drawings to illustrate styles of instruments. To use the cystoscope with any accuracy and diagnostic skill requires long, patient study and experiment, and at least three types of instrument—direct, indirect and retrograde. Careful cystoscopic diagnosis frequently saves a patient the necessity of undergoing

a cystotomy or even a more serious operation. From an operative standpoint it has a rather narrow, but very distinct field. It comprises treatment of certain stone cases, foreign bodies, ulcers, irrigation of pelvis of the kidney in gonorrheal infection, and high frequency current in the treatment of papilloma and certain other forms of bladder tumors.

Dr. Gordon McKim, in discussing the paper, called special attention to the use of the cystoscope in the diagnosis of the so-called median bar of the prostatic region, which gives symptoms similar to true hypertrophy of the prostate, and which is best differentiated by means of a correct reading through the cystoscope; that by this means what might otherwise be considered a case for major operation was demonstrated to be amenable to minor surgery.

Dr. W. D. Haines reported a case of membranous pericolicitis (Jackson), and said that since Jackson's report before the Western Surgical Association he had found four cases of this condition in his abdominal work. The cases presented in common a broad band or veil-like membranous adhesion from the colon to the anterior and lateral abdominal wall, which probably was the adhesion which was formed at some time during a true inflammatory peritonitis.

In discussion, Dr. Souther said that there had been two or three recent articles in the literature which were well illustrated and bore out Dr. Haines' cases. One of these cases was by L. S. Pilcher, of Brooklyn, in January, 1912, *Annals of Surgery*, one by Ginsburg, of Philadelphia, in October, 1911 *Surgery, Gynecology and Obstetrics*, and one by Connell, of Oshkosh, in November, 1911, *Surgery, Gynecology and Obstetrics*. These three papers are of sufficient importance to justly establish this condition as a clinical entity, and it is generally recognized that chronic constipation and obstipation and partial obstruction are fairly constant concomitant symptoms. Dr. Haines's method of dealing with the condition is in accord with the suggestions of Pilcher and others, and can be thoroughly endorsed.

Dr. Magnus A. Tate reported a case of suppurative appendicitis that did well for thirty-six hours, and then developed signs of anuria, which yielded promptly to Fischer's alkaline treatment. Dr. Tate was using the proctoclysis of ordinary saline, but the case developed the urinary symptoms in spite of this much-praised therapy. Substitution of Fischer's alkaline treatment was followed in four hours by renewed renal activity, and patient bids fair to recover.

Dr. R. W. Thomas called attention to a number of cases of anomalous appendices, one measuring twelve inches and extending down across the sacrum.

Dr. D. D. DeNeen presented a specimen of lower lobe of the right lung of a cat removed experimentally without intratracheal insufflation anesthesia with recovery.

Dr. Frank Fee presented a specimen of large stone removed from urinary bladder, and showed X-ray plate. In reporting the case Dr. Fee noted that the history showed stone symptoms for seven years, but the diagnosis had not been made because the stone was encysted and escaped the sound. Operation and removal was followed by recovery. Discussed by Dr. A. W. Nelson, who said that had the cystoscope been used the diagnosis would have been easy.

Dr. J. A. Caldwell reported a traumatic thrombosis of the brachial artery relieved by operation. Dr. Caldwell operated on his patient within a few hours of the injury, and by massage was able to cause the obstruction in the artery to disappear, and patient made a perfect recovery.

Dr. Moses Salzer read a paper on "Nitrous Oxide Oxygen Anesthesia as a Routine Anesthetic," in which he considered at length the advantage and disadvantages of the method, and made a plea for its more general use, on the grounds of its safety.

Dr. F. Hoefer McMechan ably discussed Dr. Salzer's paper, and said that, notwithstanding all of its advantages, there still was a mortality associated with its administration. He quoted a large number of statistics to bear out the statement, and said that alcoholism was a distinct contraindication to its use in nearly all cases.

Dr. Bonifield said that the breathing methods gradually coming into vogue were a reversion to the principle involved in the closed ether cone method, of which he is an advocate.

Dr. F. W. Dowling inquired as to the status of ethyl chloride in Cincinnati, and said that it was extensively used in France and worked well in throat cases and for short anesthesia.

Dr. Samuel Iglauer said that he had read a paper before the Academy in 1903 on nitrous oxide and ether. He believed nitrous oxide had a definite field, and should be used more extensively.

Dr. Salzer, in closing, said that while he would rather *give* ether, he would rather *take* nitrous oxide oxygen.

MEETING OF MARCH 29, 1912.

Dr. John E. Griewe presented a patient, boy of twelve years, seen in consultation and studied by X-ray pictures, showing an abnormally large colon and presenting symptoms of Hirschsprung's disease and obstipation. X-ray plates showed almost normal contraction of the colon in serial plates taken at intervals.

Dr. Jos. Ransohoff presented a patient who two years ago had a tubercular tenosynovitis, and in February, 1912, was operated on for apparent tumor of the cecum, the cecum and eighteen inches of ileum were removed for tubercular condition with ulcerated mucosa and tubercular peritonitis, with partial obstruction; complete recovery.

Dr. Robert Carothers presented a specimen of tubercular glands of the cervical region removed *en masse* from a lady twenty-two years old. Dr. Carothers stated that he saw less of these cases recently, since the throat men were performing the complete enucleation operation for the diseased tonsil.

Dr. J. Louis Ransohoff presented a similar specimen of tubercular glands of the neck, and stated that the dissection was greatly facilitated by the division of the sterno-mastoid muscle and its reflection up and down, laying bare the carotid region, and being able to see the vessels and better avoid them.

MEETING OF MARCH 12, 1912.

Dr. Frank U. Swing presented some very beautiful specimens of hookworms, male and female.

Dr. E. G. Zinke presented X-ray plates representing a high degree of coloptosis, as bearing on the paper of the evening.

Dr. Chas. T. Souther presented a patient upon whom he had performed a partial gastrectomy for cancer eight months ago. Patient is well, eating everything, and has gained twenty-seven pounds.

Dr. Henry L. Woodward presented as a specimen a baby, full term, hydrocephalic, with spina bifida and club feet. Delivery was accomplished by puncture of the spina bifida and rupture of the hydrocephalic head, after which delivery was easy.

Dr. John E. Greiwe presented the regular paper of the evening, "Ptosis of the Colon, Its Relation to Neurasthenia and Auto-Intoxication" (with X-ray plates). Dr. Greiwe's description of the condition, its clinical side, the relation of constipation in childhood as an etiological factor, the difficulty of absolute diagnosis, the necessity of serial X-ray pictures at short intervals as a valuable aid in the estimation of the condition or tone of the intestinal musculature, were very instructive, interesting and conclusive. *The Bulletin* can in no sense do justice to the very commendable article in extract. Dr. Greiwe's conclusions were conservative and most excellent. His conclusions from X-ray study would indicate that this is a very valuable means when properly used, and misleading if not oft repeated and properly interpreted.

Dr. Frank Rattermann, in opening the discussion, cited cases in his work to bear out the position taken by Dr. Griewe, and called attention to the relative limit of medical treatment as anything more than a palliative measure. He was inclined to divide the cases into groups where medical, mechanical and surgical treatment was indicated.

Dr. C. A. L. Reed said we are now repeating the observations and conclusions of Glenard, of some twenty years ago, and that his descriptions have to this day not been improved upon. We

are approaching this very important subject step by step, and may say that we began by attacking the loose kidney; later less kidney work has been done, and we are paying more attention to the general visceroptosis with special attention to the colon. The logic of Dr. Greiwe is irrefutable and his conclusions are good. The colon is frequently the primary offender, due to ptosis and angulation causing redundancy. A very redundant cecum has been observed in a number of recent cases. Fixation of the cecum in these cases has given good results. In the markedly atrophic colon the Lane short circuit operation is indicated. In the dilated, adherent or misplaced colon the fixation operation is indicated.

Dr. Robert Carothers said he had first seen this condition operated on twelve years ago by the hammock operation, and six years ago he saw a case with Dr. Caldwell in which they operated by a similar method, with very good results, lasting in character. He said that his attention had been further called to this condition by the work of Goldthwaite, of Boston. In a limited number of cases his results were good, with mechanical treatment. Usually these cases have a general lack of tone in the entire system, especially the ligamentous and osseous systems. They have flat feet, loose joints, etc. We are yet in our infancy in the care and treatment of these cases, and should go very carefully and select our cases so as to make very few if any mistakes.

Dr. Ralph Reed took exceptions to the use of the term neurasthenia in these cases, saying that neurasthenia was a neuron fatigue and a distinct entity, and unless so considered we must refute the teachings of all the best neurologists the world has known.

Dr. W. D. Haines called attention to the etiology, and said that until we can be more definitely causal in our surgical therapeutics we cannot hope to make much progress. Muscular relaxation and relaxation of pelvic outlet are factors in the production of symptoms, and further that there were too many remedies for any of them to be of value. Glenard said that "we may have a colon ptosis without a kidney ptosis, but never a nephroptosis without a coloptosis."

Dr. Ed S. Ricketts said that it would be well to show some X-ray plates of cases that had been operated.

Dr. J. E. Pirrung said he had been with Mr. Lane, and had examined the first case he operated, and that the patient gained greatly in weight and was well. Practically all the cases gain in weight and lose their sallow skin and auto-intoxication. Most cases are unmarried women. He does not believe that rest, massage and mechanics mean much in these cases.

Dr. Max Dreyfull said some married women were relieved during pregnancy, only to have the condition return after confinement.

Dr. Greiwe, closing, said, in reply to Dr. Ricketts, that he had some pictures of post-operative cases, but that Dr. Lange had overlooked them. In answer to Dr. Haines' question, he said that constipation in childhood was a decided factor in the etiology, and on its prevention and cure depended our greatest prophylactic measure. Evolution, *i. e.*, change from quadruped to biped, was a factor. He used the term neurasthenia to mean nerve fatigue due to toxic condition, and that it was an anatomical and mechanical condition.

Selected Articles

CARDIOPATHIES COMPLICATING PREGNANCY AND LABOR.*

BY A. SAMUEL, M.D., *Baltimore, Md.*

In order to be able to give a relative prognosis and to treat and manage pregnant patients with cardiopathies, it is quite necessary to study (1) the effect of normal pregnancy upon the normal heart; (2) the effect of dystocia upon the normal heart; (3) the effect of pregnancy and labor on the diseased heart; (4) the effect of cardiac disease on pregnancy; (5) the consideration of the question of inducing premature labor in patients with heart disease; (6) the management of labor; (7) the problem of matrimony for sufferers of a heart lesion.

In normal labor there is an increase in the size of the heart. This hypertrophy is the result of a prolonged increase in work, which is probably due in part to the dilation of the heart, and in part only suggested by the increased area of dullness, resulting from the change in the position of the heart. This change in the position of the heart is caused by the growing uterus gradually pushing the diaphragm upward, causing the heart to assume a more transverse position. The apex is not infrequently found in the fourth interspace. James MacKenzie has shown that the dilation during pregnancy affects the right heart more particularly, and that in very many cases even of otherwise normal women a definite insufficiency of the tricuspid valve may appear, disappear and reappear, and the presence of this insufficiency is shown by the positive venous pulse and the systolic murmur in the tricuspid area. This probably accounts for the appearance of accidental, non-organic murmurs during pregnancy. Various theories have been offered in explanation of this phenomena. The latest theory is that the murmur is caused by a slight kinking of the large vessels, especially the pulmonary artery, as a result

of the peculiar dislocation of the heart during pregnancy. It is obvious that special care must be taken in the differentiation of this accidental murmur from one produced by a mitral insufficiency.

II. THE EFFECT OF DYSTOCIA UPON THE NORMAL HEART.

With the introduction of reliable and practical instruments for measuring the blood pressure, great interest has been awakened in the question of the effect of a pathological pregnancy upon the cardiac function. As stated before, the blood pressure in a normal pregnancy and a normal heart was found to be between 118 and 126. In cases of eclampsia, the blood pressure may vary anywhere between 130 and 120. In patients with impending eclampsia, the blood pressure increases markedly, and falls after delivery, when the symptoms subside. In very grave and fatal cases there is an extreme increase in pressure. In edema particularly, the pressure seems definitely related to the type of the case; therefore, its observation is of value in prognosis and treatment. In cases of chronic nephritis, with symptoms of toxemia, the blood pressure remains very high, even after the symptoms have been relieved by delivery.

III. THE EFFECT OF PREGNANCY AND LABOR ON THE DISEASED HEART.

The old writers have no doubt exaggerated the dangers of pregnancy and labor upon the diseased heart. Cardiac disease at one time was looked upon as one of the most serious complications of pregnancy, and many eminent physicians claimed that about 40 per cent of women with serious heart lesions met their death in connection with child birth. While it is extremely difficult to arrive at any definite figures as to the mortality, since Fellner at Schauta's Clinic claims that a heart lesion is not recognized in more than about 14 per cent of patients, and that in 86 per cent of these patients suffering with cardiac complication to pregnancy it is overlooked because the cardiac symptoms do not become manifest, I have had two deaths in 12 cases, one of these occurring immediately at the termination of labor, and the other

three weeks afterwards. If possible, it is rather important that all patients should be thoroughly examined, in order that the cardiac complications may be detected, for more reasons than one—firstly, operative methods may become necessary to quickly terminate labor to prevent a fatality, and secondly, since the introduction of the Momburg belt constriction, the application of the belt is strictly contraindicated in the presence of any form of heart disease.

During pregnancy minor cardiac lesions are rather difficult to detect. Early signs of break in compensation may also be difficult to detect, since there is a change in the position of the heart, changes in the area of dullness, changes in the pulse rate, blood pressure and frequently accidental murmurs, or even physiological relative tricuspid insufficiency of muscular origin. Edema of the lower extremities and of the genitalia may be caused solely by the pressure of the heavy uterus against the heavy pelvic veins. The diagnosis of a decomposition during pregnancy depends, however, upon signs that are relative rather than absolute. Dyspnea and cyanosis on very slight exertion, such as quietly walking a few hundred yards, walking up a few stairs, the presence of a small, rapid pulse, persistent cough, enlargement of the liver and edema of the legs may be regarded as the most important symptoms. It may also be said, the earlier in pregnancy these symptoms occur, the more alarming they are. Statistics of the fatalities to mother and child are valueless, some authorities claiming an overwhelmingly high mortality to both mother and baby, while others place the mortality ridiculously low. I think we must all bear in mind that cardiac lesions are all more or less dangerous, and the successful outcome of both mother and child does not depend so much upon the lesion present, but to the condition of the myocardium. Valvular lesions seem to be the least dangerous; stenosis, mitral stenosis and chronic myocarditis, due to infection or intoxication, the most dangerous. The most serious consequences have been noted in first labors. This is explained probably by the difference in duration and the severity. For patients who have had several breaks in compensation dur-

ing their pregnancy, without the proper rest and care, prognosis is distinctly grave, both to the mother and child.

The greatest dangers arising from cardiopathies in pregnancy are degenerative changes in the myocardium. It must be borne in mind that heart failure is essentially a question of the integrity of the heart muscle, and this I should like to impress upon you, as in the treatment of the various forms of cardiac failure it is the integrity of the cardiac muscle which we have in every case to consider. While in the great majority of cardiopathies a valvular lesion is only an embarrassment to the heart in its work, and one which may be easily overcome, the presence of a lesion, however, is important in that it calls attention to the heart, and may remind us that the disease which has injured the valve may also have injured the muscle. Our object first is always to find out in these patients the extent of the lesion to the muscle, and how far the valvular lesion involves the muscle. In valvular lesions with little or no enlargements of the heart and a fair response to increased force, pregnancy and labor may be without terrors. If response is limited, if palpitation is readily induced by exercise, opinion should be suspended until the result of treatment is ascertained. If the condition is not improved, then the outlook is not so hopeful. It must be kept in mind, however, that some persons with valvular lesions may suffer from most severe heart failure and make good recoveries; in fact, I have in mind one of my patients who has had five children, and who has had at least 10 or 12 attacks of heart failure. During her last pregnancy she had a most severe attack of decompensation two weeks before the baby was born, yet she made an uneventful recovery, and is still living.

Mitral stenosis is more dangerous than mitral insufficiency; at least I have found it so, as I have never lost a case of mitral insufficiency during or immediately after labor, whereas I have had one death from mitral stenosis. In talking this matter over with several other obstetricians, several of them have lost cases of mitral stenosis, whereas their mortality has been nil with insufficiency. Probably the greatest complication of parturition for the mother and child is acute edema of the lungs. The resulting

asphyxiation of the mother invariably leads to the intrauterine death of the foetus. The two greatest dangers arising from the complication of a heart lesion with pregnancy are break in compensation already referred to and degenerative changes in the myocardium, with subsequent cardiac failure. One must not overlook the fact that the patient is not out of danger after delivery, for symptoms of severe heart failure may supervene any time within the next three or four weeks. In one of my patients with a mitral insufficiency who had comparatively easy and spontaneous delivery and showed no signs of cardiac embarrassment three weeks after delivery she had a bad break in compensation, and died 24 hours afterwards.

THE EFFECT OF CARDIOPATHIES UPON A CO-EXISTING PREGNANCY.

We find the most pronounced expression in premature expulsion of the uterine contents. Statistics on this point as to the relative frequency of premature spontaneous termination of the pregnancy are very unreliable. However, it may be stated with safety that it occurs in about 25 per cent of all the patients with a cardiac lesion. Premature termination of the pregnancy does not take place unless there is some break in compensation. Various causes have been ascribed. Congestion of the endometrium, due to circulatory disturbances, apoplexies of the placenta or hemorrhages between the placenta and decidua, interfere with placental respiration or the defective oxidation of the maternal blood may cause death in the uterus to the foetus from asphyxiation.

Consideration of the question of premature delivery in patients with cardiac disease is still an open one. It cannot be denied that the greatest dangers to the mother develop during labor. In women whose compensation is good, who can stand a moderate amount of strain without showing signs of fatigue, it may be safe to allow the patient to go on to term; but if a break in compensation occurs at any time during her period of gestation, it may be well to consider the question of producing abortion. This is a grave question, and should not be undertaken unless the family and another physician are called into consultation. With quiet

and rest in bed, many of these patients who have had breaks in compensation may go through labor without the least bit of embarrassment, whereas if we had terminated pregnancy, the child would have been lost. We must not lose sight of the fact that the production of premature delivery produces almost as much strain on the patient as at full term, except that it may be shorter. The loss of blood in these patients is more beneficial than harmful, and should not be considered a factor contraindicating premature miscarriage in cardiopathics. However, when we decide to terminate pregnancy, the method employed should be one that produces the least amount of strain on the patient. In three of my cases the question of terminating labor was carefully considered. One patient in particular had a bad break in compensation about the seventh month. This patient was put to bed, absolute rest, on light, nutritious diet, and the infusion of digitalis in tablespoonful doses given. After a three weeks' rest in bed she showed no further signs of a break in compensation. Notwithstanding her labor was quite long, she showed no cardiac embarrassment. I should say that with patients who showed signs of a break in compensation about the sixth month of pregnancy, and did not regain compensation after three or four weeks' rest in bed, with the use of the customary medicinal and therapeutic measures, and if the same patient after this rest in bed again showed signs of decompensation, the question of terminating pregnancy should certainly be considered. Of course, in desperate cases, where the patient is moribund, with the prospect of saving the child, the prompt induction of labor should be attempted, though this in many instances is rather useless, as by the time the baby is born it is already dead from asphyxiation.

As long as the compensation is good, the patient should merely be carefully watched. No medicines need be given. The old practice of giving tincture of digitalis and strychnine many months before labor is really of no benefit. When nature is taking care of the heart—and this is shown by a good compensation—medicine is not called for. The only time that medicine should be given is in breaks of compensation. At the first signs of a cardiac weakness, the usual remedies, such as digitalis or stroph-

anthus, should be given. Ordinarily I use a preparation of digalen in from 8 to 15-drop doses. If an immediate effect is required, I give this hypodermically. Some physicians have recommended the giving of digitalis or strophanthus at the beginning of labor. I have tried this in several patients, and have not seen that these patients did any better than those who had not been given digitalis. However, there is one preparation that is most useful in these cases at the beginning of labor, especially in primipara, and that is morphia in quarter-grain doses, and at sufficiently frequent intervals to procure the quietude of the patient. Morphia in these cases does not stop the labor pains, but gives the patient rest, and she does not exert herself, lessening the strain upon the heart. I have never found any ill effects from the use of morphia.

At the clinic of Schauta, in patients with mitral stenosis, pregnancy is terminated as soon as the slightest signs of broken compensation appear. This probably accounts for their low mortality in this class of patients.

In the management of labor in these patients one must be particularly careful. If the slightest signs of heart failure appear the patient should be instructed not to bear down. The usual heart stimulants may be given, combined with a quarter of a grain of morphia, and, if the first stage of labor is over, forceps should be applied and the woman delivered as quickly as possible. The question of giving an anesthetic in these patients is an open one. MacKenzie says he has never seen a fatality from the use of chloroform, while Hirschfelder advocates ether. In several of my patients, where it was necessary to deliver with forceps, I have used ether, with little or no bad effects. With one patient compensation began to fail at the end of the second stage of labor. I gave her several quarter-grain doses of morphia, and applied forceps and delivered her practically without pain. If the signs of heart failure make their appearance early in labor, with the cervix partially dilated, the outcome may be serious. Here you may have to anesthetize the patient, forcibly dilate the cervix and deliver with forceps, or resort to version. Version is a particularly dangerous operation when not performed by one thor-

oughly experienced in this line, as the danger of rupturing the uterus is very great; and, besides, with a cervix that is not completely dilated, a great deal of difficulty may be experienced in delivering the child, thereby throwing extra strain upon the patient by keeping her unnecessarily long under an anesthetic.

Patients with a pronounced dyspnea feel more comfortable in a high, reclining position during labor. In one of my patients the dyspnea was so great that she practically sat up in a chair during the whole period of her labor; in fact, the child was delivered with the patient seated in a large chair.

The application of heavy sand bags to the patient's abdomen during the first stage of labor and soon after the baby is born—this being done (1) to accelerate the dilation of the cervix by keeping the baby's head well against the cervix, and (2) to prevent the large abdominal vessels from suddenly filling—is a method that I have not used. To prevent the abdominal vessels from filling, probably the best way is to place the patient in bed and raise the foot of the bed to an angle of 45 degrees. If the pulse should become irregular, and especially if there is evidence of a dilation of the right heart in the third stage of labor, post-partum hemorrhage should be encouraged. Ergot is more or less contraindicated in these cases of cardiopathies complicating pregnancy, for the reason that the slight bleeding after delivery of the child is decidedly beneficial to the patient, and particularly where there is evidence of a right heart dilation.

Operative procedures should be taken with caution, and never without the consent of the family, and another physician should always be called in consultation. In view of the possible grave danger of asphyxiation attending pulmonary edema, the obstetrician should be ready to hasten delivery by instrumental measures. The giving of salt solution in these cases should be done with caution, and it should be given in fractional doses; probably the Murphy's drop method by rectum is the best method to give the salt solution. It should never be given intravenously. Asphyxiation is best treated by immediate venesection. In view of the fact that serious complications are liable to follow later, I always advise against the mother nursing her child, as the arti-

ficial feeding of the baby insures the mother more quiet and rest. Of course, if the mother offsets these advantages by mental anxiety and worry at not being able to feed the baby, it may be necessary in these few cases to allow the child to be breast-fed. In artificially feeding these children many difficulties are encountered, because so many of these children are born in a weak and frail condition, and when artificially fed the mortality is extremely high.

I have had but one patient suffering with exophthalmic goitre complicating pregnancy, and I hope I will never be called on to treat another case. This patient had quite a large thyroid, with the usual symptoms of Graves' disease. Of particular interest was her pulse beat. Prior to labor, the pulse averaged between 140 and 160 per minute. During the first stage of labor the pulse beat was 170. At the end of the third stage her pulse beat was about 190, and then it became so fast that I could not count it, while the rhythm was not disturbed and the sounds were clear. Immediately after the birth of the child she had an attack of syncope, and during this attack I could not count her pulse at all. Signs of acute pulmonary edema rapidly set in, and the rales and rattling could be heard almost in the next room. During all this excitement she began to bleed most profusely, before the placenta was delivered, and it was necessary to deliver the placenta quickly, in order to stop the bleeding. In the meantime, the baby had become asphyxiated and had died, and it looked as if the patient would follow within a short time. This rapid pulse rate continued for three or four hours, and almost every minute the edema seemed to increase. I gave her the usual heart stimulants, but they were without avail. After the heart stimulants failed, I resorted to the use of morphia, and this seemed to act like a charm. It immediately quieted her nervous condition, and, while the heart beat did not lessen, yet she was very much more comfortable, and the heavy pressure which she complained of in her chest was almost immediately relieved. After the patient remained in this condition four or five hours, I gave her another dose of morphia, and she went to sleep for two hours. During her sleep the pulse gradually dropped in the number of beats per minute. By the

next morning her pulse beat was about 135, with fairly good volume, and she complained of little or no pain. Her condition gradually improved, and about the third week she sat up for the first time. I strongly advised this patient not to become pregnant again, and to have her thyroid gland removed.

When we consider the great dangers of cardiopathies complicating pregnancy, the question naturally arises—whether women with heart disease should marry. This is by no means a settled question. We all know that when heart disease is complicated with any condition that throws an additional strain upon it, it endangers the patient's life. However, matrimony and pregnancy are not identical terms, and we do know that the great majority of women with good compensation go through pregnancy without any noticeable ill-effects. Marriage to many girls means an improvement in their social condition. It may mean a life of comparative ease as compared with the possible necessity of earning a livelihood by work. These are factors worth considering when the physician is asked the question whether a girl with a cardiac lesion should be permitted to marry. Indiscriminate denial of marriage to all women having valvular lesions may imply an injustice to many of them. In all cases of valvular lesion, heart failure may occur sooner or later, but it is an open question whether its onset will be precipitated by child-bearing, and it is doubtful if the risk of this is so marked as to justify denying her the right to marry. I should say, however, in women who have a heart lesion, with concomitant pulmonary or renal disease, one should advise against marriage. In view of the high death rate of mitral stenosis, one should be very cautious in advising marriage for these women.—*Maryland Medical Journal*.

Extracts from Home and Foreign Journals.

SURGICAL

DIAGNOSIS OF APPENDICITIS.

Blumberg (*Berl. Med. Ges.*, Oct. 27, 1909, through *Wien Med. Woch.* 1910, No. 17) describes a new symptom of appendicitis and peritonitis, consisting in a severe pain which is produced by the sudden removal of the hand that has been pressing upon the abdomen, if the peritoneum is affected. On the sudden removal of the hand the elastic peritoneum is suddenly returned to its position. If it is normal, no pain occurs, if it is inflamed, intense pain follows. This method renders an early diagnosis possible, but it does not enable us to make a differential diagnosis between appendicitis and disease of the uterine appendages.—*The American Journal of Clinical Medicine.*

END RESULT OF OPERATION IN GRAVES' DISEASE.

Dr. G. W. Crile (*South. Med. Jour.*, Feb., 1912) states that since conducting operation on the new principle of anoci-association, and recognizing the importance of Kocher's progressive elimination of glandular activity, the mortality has all but disappeared, excepting in those that are potentially dead at the time of operation. Recent statistics of all cases will amount to about two deaths in one hundred. As to the end results, when the disease is of long standing in patients of poor physical structure, and whose financial and social circumstances permit of no mitigation of the strain of life during the time of convalescence, the results are correspondingly impaired. No patient died of the disease after leaving the hospital; one was made worse by the operation; otherwise every patient was either benefitted or cured. Among the factors that influenced the end results were

the environment of the patient, the freedom from nervous shocks, the means at hand for diversion, as well as the avoidance of strain and the elimination of all nervous shock at the time of operation. The improvement began usually the next day after the operation, and continued for from six months to two years. The author regards patients as cured when they are able to withstand nervous shocks, such as fright, disappointment, worry, grief in a normal manner.—*International Journal of Surgery*.

TREATMENT OF STONE IN URETER.

Not all cases of stone caught in the ureter will require operative removal, as is shown by the case reported by F. Weisz. The patient showed all the typical symptoms and on passing a catheter into the right ureter, a resistance could be detected two or three cm. above the vesical orifice. Ten cc. of sterile, warm glycerine were injected into the ureter with the result that the calculus was promptly voided. A second, larger stone was soon mobilized, but became caught in the fossa navicularis so that a meatotomy was required to extract it. The patient has remained free from symptoms ever since.—*The Medical Brief*.

SURGICAL SUGGESTIONS.

A breaking-down sarcoma of the ilium may simulate a gluteal aneurism.

Not infrequently subacute inflammations of the Fallopian tubes will be found to be of tuberculous origin.

A mild degree of shock causes an increase in leucocytes; severe shock paralyzes the leucoblastic function.

A pulsating tumor in the side may be an aneurism of the abdominal aorta, although palpation fails to disclose its connection with the aorta.

Before performing esophagotomy for foreign body, make a final examination (radiographic or otherwise) to determine that the object has not slipped into the stomach.

Persistent dyspareunia, with no other ascertainable cause, may often be found to lie in a chronic gonorrhea of Skene's duct.

Some apparently inoperable carcinomata of the cervix will yield remarkably to repeated cauterization with the actual cautery and zinc chloride.

Any menstrual irregularity or abnormality in a woman who has hitherto been perfectly regular and normal in her menstrual periods, should always suggest the possibility of an ectopic pregnancy.

Injection into a fistula in ano of a staining solution or a colored paste makes it possible for the operator to assure himself that all branches of the tract have been explored.

It is worth while inaugurating the treatment of "idiopathic" pruritus ani by the administration of santonin or of enemata of quassia infusion—seat-worms may escape discovery on one or two examinations.

If skiagraphs show the shadow of a calculus at the neck of the bladder when the patient is exposed lying flat with the organ empty, and in the same position when the pelvis is elevated and the bladder full, the stone is in the prostate (or prostatic urethra) or in a diverticulum behind the prostate. (American Journal of Surgery.)—*Journal-Record of Medicine*.

OBSTETRICAL

INTRAMUSCULAR INJECTION OF BLOOD.

In many gynecological operations, particularly in fibroids of the womb, an operation is imperative, yet the exsanguinated condition of the patient is so marked that every interference is attended with grave dangers. Tonics act too slowly and transfusion is difficult, and not always possible. For these cases, P. Esch recommends the intragluteal injection of defibrinated human blood. The amounts employed were 15 to 30 cc. and local or general reaction was never seen. In one case the hemoglobin

rose from 25 per cent to 36 per cent in 13 days and in another from 23 per cent to 39 per cent in 12 days. Good results were also seen in pernicious anemia, and it may be an advantage to give larger doses here. In many cases bleeding was checked soon after injection.—*The Medical Brief*.

OVULATION AND CHILD-BEARING WITHOUT MENSTRUATION.

Two sisters, who had never menstruated but had raised families of children without any evidence of menstruation in their history, are reported by O. F. Blankenship, Richmond, Va. (*Journal A. M. A.*) One woman had three children; the other had been married three times and had eight. These are the only instances he has observed of child-bearing without any history of menstruation, out of many thousands of patients interrogated of examiners for life insurance companies and otherwise.—*The St. Louis Medical Review*.

EFFECT OF ATROPINE ON PREGNANCY.

Dr. G. Mueller (noted in *Wien. Med. Woch.*, 1911, No. 47, 3026) reports the case of a woman 25 years old, who, in her third pregnancy, took an overdose of belladonna. At the end of the seventh month this woman drank a tea containing leaves, stems and berries of atropa belladonna, and she became ill, there being vomiting, disturbances of vision, and hallucinations. After recovery, the fetal movements became feeble and finally ceased. At term a dead child was born, the placenta showing signs of protracted retention, containing numerous lime incrustations and showing obliteration of all branches of the choroidal vessels.—*The American Journal of Clinical Medicine*.

REPEATED MISCARRIAGES.

I wish to report a case, thinking it may be of interest to some of your readers and perhaps call forth some suggestion as to the underlying condition. The patient, Mrs. R., aged forty-

six, Hebrew, has always enjoyed quite good health except as herein described. At about twenty years of age she had a miscarriage at four months, and since that time at irregular intervals miscarriages or premature births have occurred, varying from two and one-half to six months of gestation. The last miscarriage occurred in December, 1911, at about two and one-half months, this making the fifteenth pregnancy. Except once she never has gone beyond the sixth month. In only one instance was a child born alive, this at five and one-half months, but it lived only a few minutes. Only twice have I been able to examine the fetus, which showed nothing abnormal.

This woman has a chronic interstitial nephritis of some years' duration; this condition has been suggested as an underlying cause in this case, but it could hardly be presumed that this nephritis existed at the time of her first miscarriages. The Wassermann reaction was negative. Pelvic examinations show no abnormality suggesting a cause for these miscarriages.—*International Journal of Surgery*.

THE RELATION OF THE THYROID GLAND TO THE FEMALE GENERATIVE ORGANS.

From a very interesting study published in the Canada Medical Association Journal, Drs. James R. Goodall and L. C. Conn draw the following conclusions: 1. The relation between the female genitals and the thyroid is very intimate. 2. The generative organs which stand in such close relation with the thyroid are the ovaries. 3. That the uterus is devoid of any influence upon thyroid activity, except in that its function may affect the ovarian function and through this the thyroid. 4. Thyroid activity is in a measure under the governance of ovarian activity. 5. Ovarian hyperactivity is a frequent cause of the development of exophthalmic goitre. 6. Diminished, or absent, ovarian activity usually coincides with myxedema. 7. Puberty, menstruation, pregnancy, lactation, and menopause, exercise a profound influence upon thyroid secretion. 8. Thy-

roid secretion and ovarian secretion do not supplement each other; they neutralize each other. 9. The ovary has two secreting structures—the corpora lutea and the interstitial cells. It is the secretions from the latter which seem to bring the ovary and thyroid into such close relation.—*The Medical Fortnightly*.

MEDICAL

CEREBROSPINAL MENINGITIS.

The recent discovery of the fact that the natural habitat of the organism of cerebrospinal meningitis is the nose and throat is considered by H. T. King, New Orleans (*Jour. A. M. A.*, Feb. 10), to be the most important contribution to our knowledge of the prophylaxis of the disease. With this fact also should be considered the discovery that the disease is carried from individual to individual, often by healthy carriers. The theory of direct extension from the nose and throat to the brain is untenable. The blood-route must be the one followed. In many cases the organism has been found in the blood, and it seems to have a special affinity for the meningeal tissues. There must be, however, some lowering of tissue resistance or increase of virulence of the organism, and the cause of this may, in some cases, be a trauma. The disease is undoubtedly transmitted directly from individual to individual and the number of persons carrying the infection is much greater during an epidemic than the number of patients. King estimates that nearly one-fourth of all individuals of the infected locality may be carriers of the disease without apparently showing any serious symptoms. Only occasionally do they present signs of a nasal pharyngitis or slight meningococcal infection. There are some persons who probably carry the germs permanently and perpetuate the disease. Up to the present there has been no absolutely efficacious means of causing the disappearance of the germs in the carriers, but the rigid observance of certain precautions would

limit the extent and severity of epidemics. The first essentials for this are: 1. The earnest co-operation between the people and the health authorities in enforcement of all necessary health regulations. 2. The detection and isolation of healthy germ carriers. 3. Efforts toward rendering them harmless. Thorough sanitary inspection is necessary and attention to soil pollution, especially in rural districts. Particular efforts should be made to destroy all germ-carrying parasites and vermin. Circulars of information should be distributed, school inspection should be thorough and popular lectures will also be useful. A carrier once recognized should be put under the care and observation of the health authorities and treatment directed toward disinfection of the nose and throat. All carriers should be inoculated with the anti-meningococcal serum. The results should be constantly tested bacteriologically and oral and nasal hygiene be made a routine, not only with them, but with others. Fomites, such as vessels, spoons, handkerchiefs, etc., which have become infected should be thoroughly sterilized or destroyed and special directions as to spitting, sneezing and coughing be given to all carriers of germs. By these means we may hope to minimize the effects of the disease when it occurs.—*The Medical Fortnightly*.

VOMITING IN INFANTS.

H. Lowenberg, Philadelphia, remarks that as a cause for vomiting, congenital pyloric obstruction is too rarely recognized. All cases of vomiting beginning at birth or shortly thereafter and continuing in spite of a reasonable amount of food manipulation, especially in breast-fed infants, or in artificially fed ones as well, and associated with evidences of malnutrition, are to be regarded as cases of pyloric obstruction, until it can be proved that they are not. Vomiting, propulsive in character, occurring immediately, but more often from one-half to two hours after, the taking of food or drink, sour and fermented as a rule, accompanied by visible peristaltic waves in the epigastric region,

not necessarily reversed, with evidences of gastric dilation and intestinal collapse, with partial or complete constipation, with or without a palpable pyloric tumor and a varying degree of emaciation depending upon the duration of the case, is usually indicative of complete or incomplete pyloric obstruction, and calls for treatment other than the usual medicinal or dietetic remedies. If complete obstruction can be proved, and it often can, surgery, usually a posterior gastroenterostomy, offers the only hope. If incomplete obstruction or pylorospasm be the cause, evidenced by partial constipation and stationary weight, lavage, gavage, rectal feeding and the bromides may accomplish a cure.

In direct opposition to this fatal type of persistent vomiting should be mentioned a type of persistent vomiting or "spitting up" of an entirely benign nature. This occurs in either perfectly healthy breast-fed or bottle-fed babies who persistently continue to thrive and to gain in weight. An adequate explanation for its occurrence is difficult or almost impossible of determination, and no treatment seems to be of avail. Dietetic manipulations usually give no help, and, as a rule, do harm by interfering with the infant's nutrition, making the weight stationary or causing a loss. It continues until it is spontaneously arrested. The breast-fed milk, by repeated analysis, is found perfectly normal. While a cause for it undoubtedly exists, the most plausible explanation is a vicious habit, which, perhaps, has its origin in faulty hygiene. The condition may be only cautiously diagnosed, and a good prognosis given when all other probable causes have been entirely excluded.—(*Journal A. M. A.*, January 20, 1912.)—*Virginia Medical Semi-Monthly*.

Editorial

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All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

THE TENNESSEE STATE MEDICAL ASSOCIATION.

The seventy-ninth annual convention of the Tennessee State Medical Society at Chattanooga, has just closed after one of the most successful meetings ever held. There were some 250 visitors from over the State, as well as quite a few guests from other States.

The papers read were scientific and interesting and so freely discussed that the program as outlined could not be completed. The evening of the first day was devoted to a smoker and vaudeville performance at the Hotel Patten, which was one of the most delightful entertainments ever given the society, and the afternoon of the last day was spent in motoring and sight-seeing.

Nashville was chosen as the place of meeting for next year, and the day was changed from the first Tuesday in April, which has been the date heretofore, to the last Tuesday.

The following officers were elected for the ensuing year: President, Dr. O. Dulaney, Dyersburg; Secretary, Dr. Perry Bromberg, Nashville; Vice-Presidents (East Tennessee), Dr. W. J. Matthews, Johnson City; (Middle Tennessee), Dr. Zell Shipley, Cookeville; (West Tennessee) Dr. G. R. Livermore, Memphis Councilors, Drs. C. P. Fox, Greeneville; A. F. Richards, Sparta; Guy Frierson, Shelbyville; L. E. Ragsdale, Columbia; E. T. Haskins, Newbern; Delegates to the American Medical Association, Drs. A. B. Cooke, Nashville, and S. M. Miller, Knoxville.

OUR PREMIUMS.

We again desire to call attention to our premiums—a reliable clinical thermometer in case with chain attached, and a year's subscription to *Successful Medicine*, given to every new subscriber of the NASHVILLE JOURNAL OF MEDICINE AND SURGERY. We also offer the thermometer to every delinquent subscriber who pays his back subscription and renews his subscription for another year. This offer holds good for sixty days from date. To those who receive sample copies of the JOURNAL, together with circular letter, we suggest that they at once fill out the subscription blank furnished with the circular and enclose check or money order or bill for \$1.00, mailing to our address, and the thermometer and receipts for subscription to this JOURNAL and to *Successful Medicine* will be promptly sent. We shall send statements to all our old subscribers who are in arrears in a short time, and unless the accounts are settled promptly we shall drop their names from the mailing list and turn over the accounts to a collecting agency. Our circulation has increased fifty per cent in the past six months, and we intend to add several thousand more names to the list during the year. We ask the help and co-operation of all physicians in the South to support with their patronage a journal of and for the South, operated as an independent medicine journal continuously from its establishment by the late Dr. W. K. Bowling in 1851.

SURGICAL CLINICS OF JOHN B. MURPHY.

We wish to call attention of our subscribers to the initial number of "The Surgical Clinics of John B. Murphy, M.D.," which we have briefly reviewed in our Book Notice Department. We feel that the W. B. Saunders Company have entered upon an undertaking which will be beneficial to the profession and themselves alike, and we wish them all kinds of success.

No man doing surgery can afford not to subscribe for these

books which contain the thoughts of one of the foremost surgeons in the world.

These books should be a boon to those who cannot visit the clinic of Dr. Murphy, and will be, we are sure, an incentive to each subscriber to strain every point to go to Chicago and see this great man at work.

Dr. Murphy is not only a surgeon, but he stands out pre-eminently as a teacher, and those who read these papers will necessarily learn much that will help them in their work.

Battle & Co. have just issued No. 18 of the Dislocation Charts, which completes the set. They will be sent free to physicians on request; also Fracture and Tumor Charts, if desired.

Reviews and Book Notices

Funk & Wagnalls Company have secured the American rights to "A System of Surgery," edited by C. C. Choyce, Dean of and Teacher of Operative Surgery in the London School of Clinical Medicine (Post-Graduate), etc. J. Martin Beattie, Professor of Pathology and Bacteriology and Dean of the Faculty of Medicine in the University of Sheffield, is the Pathological Editor of this important new work. It will be published in three octavo volumes and profusely illustrated with colored, black-and-white, and text illustrations. Each branch of surgery is treated by the foremost specialists in that particular branch in Great Britain, so that the work will really comprise the whole field of surgery from the viewpoint of the foremost British practitioners. Volume I will be ready about the middle of April, and the remaining two volumes will be published about autumn, 1912. The price of the work will be \$21.00 per set.

SURGICAL CLINICS OF JOHN B. MURPHY, M.D.—Volume I, Number 1. The surgical clinics of John B. Murphy, M.D., at Mercy Hospital, Chicago. Volume I, Number 1. Octavo of 133 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1912. Published bi-monthly. Price per year: Paper, \$8.00; cloth, \$12.00. W. B. Saunders Company, Philadelphia, London.

These are not students' clinics, but Dr. Murphy's famous clinical talks at Mercy Hospital, Chicago, for physicians only. A point we want to mention is that these "Clinics" are published just as delivered by Dr. Murphy, being reported verbatim by an expert medical stenographer. In this way they retain all that individual force and charm so characteristic of the clinical teaching of this distinguished surgeon. We acknowledge with thanks to the well-known publishers the receipt of the first number of this valuable publication. To those who cannot in person attend the clinics of this distinguished surgeon, the leading exponent of the art of surgery in the United States, this publication will place before them a clear exposition of the author's views and methods as to surgical operations. Next to sitting

under the teaching of this surgeon, this work enables the reader to become acquainted with practical clinical teachings as adopted by this great surgeon. These clinics are issued in serial form, one number every other month.

SURGICAL OPERATIONS.—A handbook for students and practitioners, by Prof. Frederick Pils-Leusden, Chief Surgeon to the University Surgical Clinic and Chief of the University Surgical Polyclinic is the Royal Charity Hospital of Berlin. Only authorized English translation by Faxton E. Gardner, M.D., New York, with six hundred and sixty-eight illustrations. New York: Reiman Company, 1123 Broadway.

This is a most excellent hand-book for the use of students and general practitioners. What commends itself most particularly to the reader is the excellent character of the numerous diagrams and illustrations, as well as the clearness and succinctness of the text. We have taken the greatest interest in the examination of this book, and we can conscientiously recommend it as a trustworthy guide to beginners in surgical work, and it will prove of interest and help to the specialists in this branch of medicine. We are glad to see that the author urges persistent work upon the cadaver and the dog as preliminary training in the performance of surgical operations. There are entirely too many surgeons nowadays who are totally devoid of long training in surgical methods.

PROGRESSIVE MEDICINE.—A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Harey, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; one time Clinical Professor of Diseases of Children in the University of Pennsylvania; member of the Association of American Physicians, etc. Assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia; Ophthalmologist to the Frederick Douglas Memorial Hospital; Instructor in Ophthalmology, Philadelphia Polyclinic Hospital and College for Graduates in Medicine. Volume I, March, 1912. Surgery of the Head, Neck and Thorax; Infectious Diseases, Including Acute Rheumatism, Croupous Pneumonia, and Influenza;

Diseases of Children; Rhinology and Laryngology; Otology. Lea & Febiger, Philadelphia and New York, 1912.

We acknowledge with thanks the receipt of the March number of this valuable quarterly publication. As we have remarked in connection with our reviews of preceding numbers of this publication, there is none other that so completely carries out the object of the editors—that is, to present in readily accessible form the cream and essence of all recent advances and discoveries in the realms of medicine. To the practitioner who desires to be *en rapport* with advanced medicine this quarterly is invaluable. The editors are well-known and able, and the corps of contributors selected for their ability and fitness for handling the subjects to which they have been assigned. The contents of this number are as follows: "Surgery of the Head, Neck and Thorax," by Charles H. Frazier, M.D.; "Infectious Diseases, Including Acute Rheumatism, Croupous Pneumonia, and Influenza," by John Rubrale, M.D.; "Diseases of Children," by Floyd M. Crandall, M.D.; "Rhinology and Laryngology," by D. Braden Kyle, M.D.; "Otology," by Arthur B. Duel, M.D.; Index. We cannot too strongly urge upon the profession the importance of this serial, and think that every up-to-date physician should become a subscriber.

THE FRIENDS OF THE INSANE.—The Soul of Medical Education and other essays, by Bayard Holmes, M.D., Chicago, Ill. Price, \$1.00. Cincinnati: The Lancet-Clinic Publishing Co., 1911.

This writer's strong little volume is made up from contributions on various subjects to the *Lancet Clinic*. It represents a collection of many entertaining essays on various subjects. Of these the first, treating of the management of the insane, is the most important. It is a plea for more attention being paid to efforts at curing the insane. These unfortunates are cared for by the State and at private sanitarium, not for their own good but for the good and safety of the sane. The suggestions of the author for the better care of the insane are reasonable and practicable. This first essay is exceedingly valuable and is followed by quite a number of other essays on different topics that furnish

good reading for the profession. Lack of space prevents more extended notice of these essays, but we may say in conclusion that the little volume is well worth reading from beginning to end.

TEXTBOOK OF OPHTHALMOLOGY.—In the form of clinical lectures, by Dr. Paul Roemer, Professor of Ophthalmology at Griefswald. Volume I, cloth, \$2.50. Translated by Dr. Matthias Lanckton Foster, member of the American Academy of Ophthalmology and Oto-Laryngology, with one hundred and eighty-six illustrations in the text and thirteen colored plates. Volume I. New York: Rebman Company, 1123 Broadway.

This excellent work is the outcome of a series of lectures delivered by the author at Griefswald, and has been published in response to the petition of his students who desired to keep in permanent form the instruction as given them by their teacher in his lectures. That the work will prove of value to the profession at large is manifest, as it contains the distinguished author's lectures pretty much as delivered by him, profusely illustrated and systematically arranged. We should consider the book of the greatest value to the specialist and to the teacher of this specialty.

Publisher's Department

"I wish to express my great appreciation of Tongaline, for I find that with it I can correct cases of rheumatism which are not susceptible to any other line of treatment."

"Last month I told my county society that I believe Tongaline is by far the best remedial agent that has ever been devised for the particular diseases for which it is intended."

"I am constantly using Tongaline and getting the most satisfactory results."

Chemical food is a mixture of phosphoric acid and phosphates, the value of which physicians seem to have lost sight of to some extent in the past few years. The Robinson-Pettet Co., incorporated, to whose advertisement in this JOURNAL we refer our readers, have placed upon the market a much improved form of this compound, "Robinsons Phosphoric Elixir." Its superiority consists in its uniform composition and high degree of palatability.

THE INSOMNIA OF ALCOHOLISM.

Of all the insomnias, the most difficult to control is that of acute alcoholism. Not only is there wakefulness during the period of convalescence from the restless tossing to and fro, remorse, and gloomy anticipations of the future. In these cases the more recently discovered hypnotics do not reach the bottom of the trouble. Bromidia has a profound influence on the entire nervous system and exercises its sedative effect thereon before the actual hypnotic result is prolonged. The ultimate result is curative, for the effect on brain and cord does not immediately wear off. Furthermore, far from causing anorexia, as similar agents are prone to do, Bromidia actually increases the appetite, a very valuable help in these cases where it is important to build up the system as soon as possible. In all alcoholic cases, the

use of Bromidia is greatly to be preferred to the hypodermic injection of morphine, with its inevitable result of locking up the secretions, and its frequently disastrous action on the stomach. If opium must be used, Papine will accomplish what is desired without any of the bad effects of morphine.

TREATMENT OF RHEUMATISM.

Rheumatic and gouty patients are greatly benefited by the administration of Ecthol in combination with salicylates. Its use prevents complications and lessens the liability to recurrences. The application of a mixture of equal parts of Ecthol and oil of wintergreen to the affected joints, several times daily, materially relieves the pain and swelling and assists the internal treatment.

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NASHVILLE JOURNAL — OF — MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

VOL. CVI.

MAY, 1912.

No. 5.

Original Communications

NERVOUS DISORDERS AND THE NEUROLOGIST IN RELATION TO THE PROFESSION AND THE PUBLIC.

BY TOM A. WILLIAMS, MB., C.M., EDIN.

Washington, D. C.

*Membr. Corresp. Soc. de Neurol. and Psychol. of Paris. Am.
Psychopathological Assoc., etc. Neurologist to
Epiphany Free Dispensary.*

It is unfortunate that the name of neurologist has been assumed so generally by charlatans without pretensions to even the elements of medical science and skill. Of course, we medical men know the difference; but the laity may be grossly deceived. But of the other term, "psychotherapeutist," coming within the scope of this paper, a clear differentiation is not always made even by physicians, who have allowed medical amateurs of various kinds to pre-empt the psychic treatment of disease, to the great detriment of the public, and with a distinct diminution of honor to the medical profession; for the fact that we have permitted the intrusion of any blatant pretender to psychopathological knowledge indicates to the public our own shortcomings in that science.

The functions of the neurologist of the old school, some of whom survive, were confined to refinements of diagnosis in matters of organic nervous disease, in most of which treatment,

as then conceived, was of little avail. This is nowadays regarded as a very small though still essential part of a neurologist's work. Although of course it is impossible that all and sundry can learn from him, however excellent a teacher, diagnostic refinements which have taken him years to acquire, yet a modern neurologist should be a source from which should flow a fertilizing stream of knowledge conveying at least the broad principles of the advances of neurological science and art. These are tremendous, and only one who specializes is capable of compassing and estimating them justly. The making acquainted his professional brethren and the laity with the advances of neurology is the counterblast and antidote against the always pernicious doctrines of the psychologist-amateur, the cracked-brain enthusiast of psychic phenomena, the religious doctrinaire who affects the art of healing, and the most widespread of all, the advertising charlatan who seizes upon and perverts each new scientific acquisition with which at once to terrify and give promise of cure to a credulous public.

The more this is done, the clearer will medical men see that neurology, like the rest of medicine, perfects itself by observing and analyzing phenomena which appear to resemble one another, until characters are found which show their essential difference. When this is done, the phenomena are re-grouped in another synthesis or series according with characters which are essential. These principles in general medicine have led to such distinctions as those of renal from cardiac albuminuria, typhoid from typhus fever, catarrhal from croupous, of scrofula from neoplasm. The groupings may be illustrated by that which brought together pulmonary pthisis, tabes mesenteric and struma cervicalis into the common rubric of tuberculosis.

It was by these means that from the layman's rubric of "paralysis," Duchenne was able to separate motor disability into the three types of spastic, flaccid and ataxic. Since then, more numerous distinctions have enabled us to still further classify these types; and in combination with sensory symptoms and modification of the reflexes to construct a nosology which would have been unrecognizable fifty years ago.

The syntheses of modern neurology are perhaps best illustrated by the myopathies and the dyskineses. The separately described types of muscular atrophy—Landouzy-Dejerine, Erb-Klunke, pseudo-hypertrophic, facio-scapulo-humeral etc., after being first differentiated from the spinal myopathies and the neural degenerations, are now grouped together into the nosological entity of primitive muscular dystrophy.

Analysis of dyskineses shows that their fundamental character cannot be determined by tonicity, clonicity or by situation or intensity of movement, but must be ascertained by its genesis above all, although certain subsidiary characters are often confirmative. By this, the usual process of clinical medicine in differentiation, Brissaud demarked the tics, the knowledge of which is so important in the prognosis and treatment of nervous disease.

But the neurologist, like all scientists, does not stop here. He knows that only by the experimental method are some problems to be solved. It is by the application of this method that the phenomena of hysteria have been elucidated. In producing at will by psychic means hysterical phenomena and by removing them when desired, the psychogenesis of this disorder has been clearly established.

Not only this, but psychogenetic mechanisms have been and are being studied in animals. The epoch-making work of Pawlow need only be mentioned, so well-known is it.

These clinical supplements to post-mortem studies lead us to divide the causes of functional perturbations of the nervous system into three classes.

I. Alterations of the structure of the nervous system, as by inflammation, infiltration or degeneration.

II. Alterations of the medium in which the neurones have to perform their work by chemical substances, whether infections, intoxications or perverted secretions.

III. Alterations of the forces by means of which the neurones act harmoniously with one another.

Only when these dynamic disorders are confined to the lower neurones, should the term neurosis be applied, *e. g.*, angioneu-

rotic œdema and other disorders are entirely beyond the control of the patient by any psychic means whatsoever.

But when the disorder is generated, either from within or without, by impressions upon the sensory apparatus which arouse and associate themselves with the stored-up impressions of other portions of the cerebrum to form a psychological unit known as idea, whether accompanied by emotion or not, then we are entitled and indeed compelled to use the term *psychosis* for such a disturbance. The symptoms of hysteria certainly arise by means of this kind of mechanism. It is a moot point whether the symptoms of psychasthenia also arise thus. At all events, it is quite clear that an understanding of this genesis will prevent a clinician from confusing hysteria, really a psychosis, with such a neurosis as excessive motor lability. The mixed term psychoneurosis is no more rational than are such exploded parallels, typho-malaria and typho-pneumonia. There is no more essential connection between psychosis and neurosis than between typhoid, malaria and pneumonia.

I have found that a grasp of these principles greatly aids a practitioner in knowing when he requires to consult a neurologist; for he will not be content with such vague, indeed unintelligible notion as "hystero-neurasthenia," as expounded in the textbooks. If he is a clear observer, his experience has shown him the frequent failure of the therapeutic blunberbuss recommended for these cases, and he wants to know why he failed with some and succeeded with others. Even though he can eliminate structural disease, he often finds himself incapable of a pathogenic diagnosis, and it is then he realizes the need of assistance.

Nothing has been more gratifying to me in Washington than the successful issue of cases where patients have been seen for the purpose of making such an analysis in order that the physician might feel that he was directing his therapeutics in the right way.

This is the more so as it is impossible for a neurologist to himself treat all the cases he sees, time lacking and energies being limited. Besides, every doctor who cures a neurological case after consultation feels his power much added to and him-

self become a sun of flaming ray to scorch up the weed of charlantry. A relation of a few such cases will be instructive.

HYSTERICAL TYPHLITIS AFTER APPENDECTOMY.

Case 1.—A girl of twenty was referred by Drs. Watkins and Stavely because of recurrences of right iliac pain with nausea and vomiting, but normal temperature and pulse, since three months. Two months before the appendix had been removed for similar symptoms, and found little changed, though containing a concretion of lime. At the time the ovaries and gall bladder were found normal. The pains recur every few days, and last some hours, and were relieved by morphine or the Scotch douche. Examination showed only a psychogenic hyperaesthesia in the right iliac fossa, controllable by indirect suggestions. Some colonic atonia, a slight retroversion and intestinal sand could not explain a manifestly psychogenic tenderness. So after a few days Dr. Watkins, armed by conviction derived from the consultation, entered the fray, and after a struggle of nearly two hours convinced the young woman that determination to conquer a longing for the comforting and anodynes which sickness brings would cure her. She went back to Illinois next day, and remains well.

Such rapid success is not common. The following similar case illustrates the need of persistence in persuasion.

Case 2.—*Coccyodynic Neurasthenia from Hysteria.*—A girl of thirty-four was referred by Dr. Lemon because unbenefitted by uterine suspension, amputation of the coccyx and other gynecological measures. She was lying stiffly in bed for fear of hurting the coccyx, with intense right iliac pain and tenderness. I found the latter modifiable by suggestion, as was the stiffness. There was a false *i. e.*, volitional, Kernig's sign, and the reflexes were sluggish. She wore the martyr smile. She professed anxiety to recover and go to work. Her condition was manifestly psychogenetic; but her sister's belief in its organic nature hindered recovery, in spite of the persistency of Dr. Lemon. But at my instigation he kept persuading, until finally improvement began, and one day the young woman, determined to put it to

the proof, went to work, succeeded in the fierce struggle against giving way, and is now more capable than she has ever been before.

Case 3.—Hysterical Hemiplegia from Worry; Simulated Babruskitol.—A chief clerk, aged 54, always rather peculiar in disposition, was seen with Dr. Clayton because of hemiplegia which occurred suddenly, apparently in his sleep one night. He had no pain, but was numb all over, could not get up properly, stuttered, lisped, his tongue seeming tied. At 11 a.m. Dr. Clayton found the right eye wider than the left (equal next day), and that all movements could be made, but the right grip was weaker than the left. He thought it hysterical on account of the history. In a few days he became completely hemiplegic, Dr. Clayton being doubtful. I then saw him.

Deep Reflexes were equal and not exaggerated; but volitional contraction suppressed right gluteal reflex. The right toe extended on stroking the sole. This, however, was done voluntarily. We shall discuss this later.

Motility.—The right arm was quite motionless, but moved when he yawned; the leg moved with difficulty; the contralateral synergic responses were equal, however. He stuttered in speaking. Sensibility was normal.

Psychic Examination.—This showed the pathogenesis. He was particular to old maidishness and dyspeptic all his life. He was subject to petty worries and easily annoyed. Lately he has feared losing his position to a pushing subordinate, and little family worries have occurred. A son had studied medicine; and he himself often had gone to the lectures, by which knowledge he understands the mechanism of his affection to be "a failure of the will to connect with what moves the arm." He defied me to make him move the arm by suggestion.

Treatment.—Entirely acquiescing, I explained the fault as not in the connection, but in the controller himself, and admitted my inability to make his arm move, but declared that he could by practice. Having disarmed him thus, I easily inaugurated movements on the spot by suggestion, and he flexed and rotated the forearm and moved the fingers. Then his wife and doctor were

called and shown the improvement. An encouraging prognosis was given, and a week's horseback tour advised. The iron was not struck while hot; so he did not recover for some time, but is now well.

This case is a strong recommendation to neurological consultation. The simulation of Babinski's reflex could not have been detected without a very thorough training in clinical neurology. Again, the psychotherapeutic tact which acquiesced in his rebelliousness emanates from a clear grasp of the psychopathology of hysterical incapacity. It was only after I had made this move that I explained to him the genesis of his affection, showing that it was in the first place a defense reaction against his business and domestic troubles, a desire to escape from which caused the reaction in the semi-consciousness of a troubled night* which dramatized one of the pictures he had memorized as an amateur of medicine.

Case 4.—Hysterical Phobia of Vertigo Founded Upon Slight Arterio-Sclerotic Occurrences.—A clerk of 53, sent by Dr. H. A. Parker, because fearing crowds and anticipating evil. A hypertrophied heart, a blood pressure of 200, albuminuria and vertigo had been improved by nitrites, warm baths and less meat. Pressure now 155. Lues treated seventeen years ago. Now he often veers in walking and once fell in the street. He worries over small matters. He has "blank" attacks lasting for a second or so.

Reflexes.—Slight inequalities everywhere.

Sensibility.—Attitudes not clearly perceived, especially on right wrist; otherwise normal.

Motility.—Normal save a slight spread of the right foot in walking.

Rotation Tests.—Negative; no nystagmus. Thus cerebellar and vestibula anomalies could not be the cause of the alleged vertigo.

Psyche.—No defects nor anxieties.

*See author's "Genesis, Hysterical States in Childhood," *Medical Record*, Oct. 2, 1910; also "Hysteria, Nature of," *International Clinic*, August, 1908; "Pseudo-H," *A. J. Med. Sc.*, August, 1910.

Treatment.—So it was explained that his fear of vertigo was suggested by his former real vertigo, which had greatly improved, so that he could be reassured; for there was no organic disease of the nervous system other than a slight arteriosclerosis. He was not likely to grow worse if he followed his doctor's advice. He continues at work six months later.

Case 5.—Supposed Hysteria from Cardiac Dyspnoea in a Christian Scientist.—A woman of 64 was recommended by Dr. Ramsburg because the Christian Scientist healer was feeling her limitation, and "wanted a nerve specialist." It is possible that she believed a neurologist was more likely to diagnose a psychogenic affection, and thus indirectly justify her treatment. The poor woman had for months been forcing herself to ignore the intrusions of "mortal mind," and had made a valiant struggle against insomnia, dyspnoea, anguish and fear, due to a greatly hypertrophied heart with failing compensation (pulse, 120), and arteriosclerosis, possibly contributed to by an old hyperthyroidism. There was no albumin.

She was advised to go to bed, take light diet and call in a proper doctor; and I was most explicit to the healer, who was convinced, in spite of herself, that here was something against which her doctrines availed nothing. They did not go to the doctor whom I had recommended; but I am told that the woman's condition is now tolerable.

The Mental Alienations.—A most important function of the neurologist is presented by cases of severe nervous perturbation due to the prodromes of some major psychosis leading to legal insanity.*

"Hysterical" Behavior Due to Dementia Praecox.—An example of such a case was referred by Dr. A. E. Miller.

Case 6.—It was a youth of 23, who declared to me: "I can hardly express my trouble, not finding the right words. It sig-

*See "Differential Diagnosis of Neurasthenia," Arch of Diagnosis, 1909, Jan. Charlotte Med. Jour., June, 1909.

nifies vocation and environment, *i. e.*, to find the pursuit which fits me." This declaration was suspicious, although many an ill-instructed lad might at times have rational doubts as to his career, and become mentally disturbed by difficult environment such as this boy's who was in the government service after a university course paid for by working his way and by the hard earnings of his father, a mechanic.

The psychoanalysis, however, soon revealed that during a previous breakdown, "confused by and deferring to his father's authority and the outside influences, he yet felt within a light penetrate his brain with prophetic fire." A ball of fire in the sky was later interpreted as a sign, but the Chancellor explained it was simply Jupiter. Two years later the "sign of love," the call of man for his mate, "brought him to the District of Columbia."

The analysis is too long to detail; suffice it to say that several weeks of insomnia produced an excitement and erratic and libidinous behavior which drew attention. It was not difficult to diagnose dementia precox. The importance of the diagnosis is the sparing of expense to a family ill able to afford it.

Supposed Hysteria Due to Amnesia by Sclerosis.—Loss of memory is often the first index of some neurological condition. To determine the source of this sometimes needs all available technique.

Case 6.—A woman about 50, referred by Dr. Ballock, is an example of aphasic amnesia of organic cause.

It is characterized by emotional distress and fear of insanity due to the loss of power to express the thought in words, although the patient feels that the idea is there, and can sometimes explain it in a periphrasis. My patient, even after ten minutes' study, is unable to recall and relate in words the story of Noah Webster. The following is her account, with much questioning. It begins with N. Noel? No. Noah? No. Newel? No. Noah? That's like it. Recognizes Webster. College? Yale. Profession? Lawyer. What did he do when young? Taught school. What else? Don't know. A book? Yes. Kind? Don't know. Dictionary? I suppose. Date? 1790, too late. Why? My idea earlier, but I don't get the rest. Was it in war time? The

other one. Name? Against whom? All other kinds in United States. Civil? Yes, that is it. Date? 1861. Did Webster live then? Too soon. Against whom, then? He was not old enough. Don't remember now, though he taught school.

She did not recollect the capital of Germany, nor in what country Edinburgh was situated, although she had once been a school-teacher; but she could reply quite intelligently to any question if she remembered the word to answer, and she could read and write; but in the latter there were frequent omissions of words, of which she was quite aware and deplored it. She could not recall the word she wanted, although she at once recognized it when proffered. Her condition intermitted more or less, but never became normal. The importance of the case is its diagnosis from a purely psychic amnesia, and to ascertain whether it was not due to a chronic intoxication or whether it was caused by the cerebral necrosis of arterial defect, as I finally decided, as metabolic treatment failed to ameliorate the condition, and its oscillations were very slight. That it was not a psychic case is shown by its entire unamenability to psychotherapy, by its genesis apart from any psychological cause, and by the nature and extent of the responses to psychometric tests too long to detail here.

Simulated Disease.—The detection of this is often a task of the neurologist. In my case of simulated hysteria described last year at the Tri-State Medical Association you will recollect that a criminal had been so often examined by physicians unaccustomed to the technic of clinical neurology that he simulated consciously the hemianaesthesia of the hysterical type, *i. e.*, (1) extending to and ceasing at the midline, (2) absolute and (3) affecting all segments equally in the same limb. Although of course he was not amenable to persuasion, he was detected by reacting to pain while his attention was diverted.

Case 8.—Simulated Quadrantic Hemisianopsia.—An ex-sailor of 41 was referred by Dr. Henning, to whom he had been sent by Dr. Burch because of inability to perform more than light work. He has a small pension and *has applied for an increase.*

*Translations, 1910; also Am. Jour. Insanity, Oct., 1910.

He declares that he was believed an epileptic in the navy, and that since the accident of falling out of his hammock while asleep fifteen years ago (from which he came, too, totally blind, remembering nothing), life has seemed a dream, it is hard to understand people, his memory is poor, and he is very nervous on the street, not being able to see out of one side of the eye, and bumping into objects.

As the hemiopic person always carries his head turned toward the side of the sound retina and has to turn his head still further to see objects on that side of him, I suspected this man at once; for there was no deviation of the head. I accordingly nonchalantly asked him to move a dark screen so that he could be hidden while stripping. He did this in a dark corner without any head movement to indicate loss of vision in the periphery of either visual field. But on approaching the field with test objects in the usual way, he declared that objects were only seen as they impinged upon the right upper retinal quadrant, *i. e.*, below and to the left.

As to his apparent good faith there was added a loss of the right achilles reflex, and some inequality of others along with an uncertainty of the sensibility to the diapason on the maleolli. It was necessary to confirm either the patient's opinion that his visual field was restricted or my own that it was not.

As the pupils reacted normally and the optic papilla was not diseased, an anterior lesion was excluded. The diagnosis of simulation was clinched by his wincing when I placed before the right field of the right eye the percussion hammer with which I was ostensibly testing the orbicular response to a tax on the facial nerve. This took place, both from above and below, on the left and right side, and conclusively proved that he actually perceived objects with all parts of the visual field.

It is hardly conceivable that such a syndrome had occurred by suggestion in medical examination, and I believed that it was intentional. This was proved when he visited me for the second time, after I had told his doctors what I had found; for on presenting the hammer in the same manner as before, no wink occurred, the patient staring fixedly before him and declaring that

he saw nothing except when the hammer was below to the left. It was, however, easy to show that he was feigning, by holding opposite the mid-horizontal plane of the eyeball, just within the visual field, two strips of color. He saw only the one color; and when they were reversed similarly. But he saw the colors which impinged upon the blind field, and not that upon the field which saw. Hence his feigning was deliberate, as he had suppressed the reaction by which it had been formerly detected, and yet still showed, unknown to himself, that his blind field saw.

In alleged tramatic neuroses, a neurologist properly trained can be of great use. Of genuine cases I could report several, cured by their own doctor after consultation.

Differential diagnosis of parakineses, dyspineses and myopathies, loosely called choreiform, is an important neurological duty, if success is desired in treatment.

Case 9.—Barking and Bowing Tic of Hysterical Type.—A striking instance of the success of rational procedure where empirical ones had failed occurred in a young Hebrew in North Carolina with ileocolitis. He suddenly developed on going to bed one night an intense clonic contracture of the recti-abdominis and diaphragm. This recurred every night, often keeping him awake for hours. It became less and less controllable, and soon occurred on sitting during the day. Then it began to come on standing, until his life was a burden. The application of electricity with the fervid assurance of its efficacy had made no impression; nor did "powerful and infallible" medicines. The boy came to Washington, and was at once referred to me by his physician, Dr. T. C. Martin. On recognizing that the disorder was a tic of hysterical type*, the psycho-motor discipline devised by Brissaud was employed. In this case it consisted of inducing the patient to perform slow, even rythmical contractions of the recti, while taking slow, deep breaths. In this way, control was gained over the muscles, so that when the paroxysms were about to begin, he had now a means of mastery, and substituted the newly learned movement for the automatic one which formerly took its own bent. He learned in one day, too quickly, as it

*See Tris & Sharens Month. Cyclopedia, Jan., 1910.

proved; but after a slight relapse two days later, another sitting cured him, and he was shown recovered. Even for this very simple case empiricism had failed where a little psychopathological knowledge reached the cause, and led to the very simple means used for its removal without either psychoanalysis or reconstruction of the mentality. Such a symptomatic cure must of course be extended to a pathogenic one, *i. e.*, the re-education of the patient's hysterical ability.

Clinical Acumen not Replacable by Laboratory Diagnosis.—Before the Wasserman reaction and examination of the cerebrospinal fluid were available, perhaps the most important diagnostic function of a neurologist was the detection of syphilis of the nervous system. There is a widespread belief that these laboratory methods have put an end to the need of the technique of clinical neurology. This is by no means the case; for of tabetics only 50 per cent react to Wasserman's test, and even cytological examination may be negative for a time in a few cases.

I have already reported (N. Y. Med. Jour., Mar., 1910; Va. Semi-Monthly, Nov., 1909), two "neurasthenic" cases which by means of refined clinical methods were correctly diagnosed as pre-paresis and pre-tabo-paresis, and in consequence of the early treatment thus made possible are now completely recovered.

Early Diagnosis of Tabes-Dorsalis.—I wish here to report a case of pretabes in which the clinical signs enabled me to persist in this diagnosis in spite of a constantly negative Wasserman reaction, and the clearing up of bladder symptoms under local treatment. By pre-tabes is signified the pathological condition of chronic luetic lepto-meningitis involving the spinal roots or cranial nerves.* The irritation of the nerve fibres is characterized clinically by pains of variable kind, paresthesiae, hypoaesthesiae rarely hyperaesthesiae of the limbs, trunk and viscera; usually diminution of the reflexes, hypotonia, some asthenia and occasionally temporary paralysis and muscular atrophy.

I persisted in this diagnosis because of the radicular distribution of intermittent burning and twisting pains on the internal surface of the right leg, along with a loss of the Achilles and

*Pathologic Prodromes of Taboparesis, Med. Record, Feb., 1910.

right patellar, and gluteal diminution of left patellar and bulbo cavernosus reflexes, along with a hypotonia of the hamstrings and a slight Romberg of the right leg with diminution of deep sensibility, and slight hyperaesthesia of the lower lumbar and upper sacral segments. It was not until after a mercurial course which cleared up the symptoms for a month, that a lumbar puncture was made revealing an increase of plasma cells. Ehrlich's salvarsan was then given, with relief for only a week; and mercury has now been resumed. In the meanwhile a partial positive Wasserman reaction declared itself.

Thus the correct interpretation of neurological signs has spared five months of degenerative changes to a patient to whom early treatment is of the profoundest importance.*

The proper treatment of intra-cranial neoplasms, their early removal, is possible only when diagnosis is made before most practitioners will suspect a tumor. The need of a thorough examination by one versed in neurological technique was insisted upon at a recent symposium here, and need not engage us tonight.

Nontabetic Ataxia.—Ataxia is a symptom which does not mean tabes in all cases. It sometimes comes from cerebellar disease,* sometimes from disease of the peripheral nerves and may be psychic occasionally. It is a delicate neurological task sometimes to make these distinctions, which are of the greatest importance in prognosis and treatment.

I have under consideration three cases of cerebellar defect. One of eleven years' standing, due to malarial thrombosis, for which nothing can be done; the second of unknown origin, similarly hopeless, a third seen recently, probably of familiar type. A fourth case, a child of four, was the progeny of a diabetic mother, and is possibly due to a genesis of the cerebellum. A fifth case recently seen at Norfolk in consultation with Dr. Lile, of Lynchburg, showed marked ataxia of cerebellar type. As it was a child under seven, one might have suspected congenital dystrophy, but a progressive dementia made one believe it a case of

(6) See "Treatment of Parasyphilis of Nervous System." Transactions of Am. Therapeutic Association, 1910; also in Month. Cyclopedia, Dec., 1910.

juvenile paresis, which opinion was confirmed by a positive Wasserman reaction.

In the differentiation of *convulsive movements*, too, neurological knowledge and skill are essential. As for example in the convulsive attacks of symptomatic epilepsy, of which I have spoken in a recent article giving examples in which early diagnosis led to proper treatment and arrest of the causative process, which was sclerogenic toxicosis.

It was adequate neurological diagnosis again which differentiated the condition of these patients from epilepsy proper.

Narcolepsia.—Fits of various kinds have to be differentiated from one another, not only as to characters but as to pathogenesis. I have recently seen four cases having *narcoleptic attacks*.

One occurred in a young man of nineteen from cyclical intoxication, possibly through pancreatic disorder, as he showed the Cammidge reaction in the urine, and was intolerant to meat proteid.* It was possibly congenital, as his sister had gone through a depressive episode of confusional type of metabolic origin.

The second case occurred in a boy of eighteen, who on several occasions lost consciousness for three hours, the first time after drinking cold water on a hot day. He has a slow pulse, and eats enormously of buns and ice cream and drinks a large amount of coffee. There were no epileptic phenomena except irritability and sullenness of temper.

A third case (a girl of twenty-two) of narcolepsy has gained forty-five pounds in weight in four months, and had sudden dimness of vision and loss of memory. Suspecting pituitary enlargement, the visual fields were examined, and showed respectively lateral and inferior partial scotomata. The X-ray showed a deepened sella turcia.

It would have been gross error to have given bromides to any of these cases. All are doing well, the first and second upon proper diet and hygiene, and the third by X-ray treatment of the

*"Diagnosis of Diseases of Cerebellar Apparatus," Arch of Diagnosis, Jan., 1910.

pituitary hyperplasia, which immediately terminated the narcoleptic attacks and removed the headaches and depression. But it was neurological experience which permitted of the diagnosis.

The pathogenetic interpretation of nervous symptoms due to arterio-sclerosis is of great importance from a therapeutic point of view. Three such cases will be published this month, all successfully treated are now at work as a result of correct diagnosis. They were seen with Drs. Ray, Balloch and Altman, respectively.

Intermittent Claudication of Labyrinthine Vessels Mistaken for Psychasthenia: Cured by Opothrapy.—Vertiginous attacks in a woman of twenty-nine referred to Dr. Barton, had endured for years. "Groaning" in the head ushered in the attack. An aurist had treated her without avail. She frequently fell, always forward; and sometimes vomited during the attack. A perfectly natural phobia had developed in consequence, which caused Dr. Barton to diagnose psychasthenia, and thus sent the case for advice.

The absence of objective neurological changes, as well as of initial psychic disorders, and the presence of dermatographia made me believe this a vasomotor neurosis, due perhaps to adrenal aberrance. I recommended adrenalin extract, and she has only had one attack since taking it, and is in every way in better health. Now this case might have been diagnosed epilepsy, cerebellar disease or hysteria, as well as psychasthenia by an observer not well acquainted with the interpretation of neurological signs. And an operation, bromides or psychotherapy might have been tried without benefit to the patient, and to the discredit of our profession.

The Relics of Poliomyelitis.—Only by a skilled neurological examination is it sometimes possible to predicate a former poliomyelitis. I have seen a number of cases lately which illustrate this. Complete paralysis of one serratus magnus was all that remained of a poliomyelitic attack, which had caused unilateral tremor, hyperaesthesia and oculo-motor paralysis with some weakness of the arms in a woman of 30 referred by Dr. Dunlop.

In another case, which had not been diagnosed during or after the acute phase, although examined by three well-known Boston

men, was referred to me four months after the attack for electro-diagnosis by Dr. Dunlop, who suspected that a weakness of the legs might be poliomyelitic. I found the Achilles reflexes absent and the right sural muscles irresponsive, and the left hardly so even to strong currents. On the one side, excitability of the anterior tibial group was diminished, and on the opposite side that of the peroneal; and one rectus abdominus was less excitable than its fellow. The diagnosis of multiple neuritis, which had been given, was utterly inconsistent with so unequal a distribution of muscular atrophy and the absence of sensory symptoms. So I affirmed poliomyelitis, a diagnosis which the patient saw confirmed by Starr, Schaffer and Holt of New York. A proper neurological diagnosis in the first place would have spared this child much delay in treatment.

Sexual Aberrations.—In disharmonies of the sexual functions a neurologist may afford much help to practitioners unacquainted with psychopathology. It is necessary to find out whether simple asthenia, hysterical fixed idea, or psychasthenic obsession or phobia is responsible for a psychic abnormality of the healthy sexual life. Besides this, the affect of shame, which has become attached to much of the sexual life through prudish misconceptions of social relationships, is often an important element in the life of neurotic patients. After it has been unravelled by a psychopathologist, I believe it quite possible that an intelligent physician interested in this aspect of therapeutics might well conduct the re-education and guidance of such patients. It has not yet fallen to me to collaborate in such an arrangement, all the doctors consulting in such cases preferring that I myself should conduct the treatment.

I have related only successes. Of course there are failures. If I have not cited them, it is from no intention to misguide you by rose-tinted lenses. But it is high time that the prevailing *non possumus* which is fashionable to cry regarding nervous disorders be substituted by an attitude more rational, because more true. So I have adduced facts tonight merely to show the absurdity of the current pessimism. It is only the cry of the incompetent and of him who has observed only the work of

the charlatan or quack. He, however, who thinks that cures can be effected by assurance without knowledge, vastly miscomprehends modern neurology and has reason for pessimism.

The Use and Need of Real Neurologists.—In these days of howling from the mountain top, only the expert is competent to estimate the value of claims in the more recondite fields of human knowledge. As the Scotch say, "Facts are chieils that winna ding." The facts that I have laid before you are pregnant with meaning for those who think. They show how greatly therapeutic power is augmented by the diagnostic assistance of a properly trained neurologist. I have taken it upon myself to present this thesis because I have been convinced it is hardly at all realized, and because we see so widely and deplore so much the vogue of the illicit medical practice which preys mainly upon the very patients who are most in need of neurological diagnosis.

It is incumbent upon us to see that proper neurological training is given to the coming generation of medical men.* To do this properly, trained men able to convey their knowledge clinically, must be appointed and given facilities in the hospitals, so that students and medical men can receive the benefit of the advance of knowledge and power. Only in this way can we combat the charlatan.

Of the even larger work of neurological science in aiding social measures against disease, time will not allow me to speak. But even the laity are beginning to realize the need of special assistance in preventing mental unsoundness, in neurological inspection of children, in sociological measures for helping people who are peculiar, in the means of preventing crime and of reforming criminals. In all these, the science of psychopathology is indispensable; and every enlightened body of laymen would be the better for the assistance of a neurologist of deep learning and broad outlook.

*See "Requisities for Treatment of the Psychoneuroses and the Abuse of Psychotherapy by the Voice of Laymen." *Old Dom. Jour. Mount Cydt. Cal. State Jour.*, etc., 1909. July, August.

Selected Articles

From the First Surgical Clinic of the Royal Hungarian University at Budapest (Hofrat Prof. Julius Dollinger, Director).

THE SERUM TREATMENT OF SUPPURATIVE PROCESSES.

BY DR. EMERICH GERGO, *Assistant of the Clinic.*

(Translated from the *Deutsche Zeitschrift für Chirurgie* for the *Nashville Journal of Medicine and Surgery* by Howard S. Jeck, Ph.B., M.D., Nashville, Tenn.)

Induced by my chief, Hofrat Prof. Dollinger, I began to test the practical value of antiferment-serum treatment a year ago. One hundred and sixty cases, which I observed most carefully, constitute the basis of my report.

For many reasons I cannot go into a searching discussion of the practical methods of employment; moreover, I can assume that the technic of the procedure is known*, whether it be by injection or serum-bath, serum-dressing, etc., and shall confine myself to the results of my work.

First of all I shall describe the clinical observations, which are of the greatest importance.

CLINICAL OBSERVATIONS IN THE USE OF ANTIFERMENT.

I. In Abscesses of the Soft Parts.

(a) The Advantages of the Treatment.

In the treatment of abscesses of the soft parts (128 cases), "the domain of antiferment treatment," as E. Müller expresses it, I became conversant with the following advantages of the treatment†:

*From a lecture in the Surgical Section of the 16th International Medical Congress at Budapest, Aug. 31, 1909.

†As antiferment serum. I use, for the most part, ascitic fluid, which is very excellent. Less frequently I employ hydrocele fluid, and recently I have also used Merck's *Qeukofermantin*.

1. *The method of procedure is extremely simple and can be accomplished in a very short time (4—5 minutes).*

The site of the operation is painted with tincture of iodine, only a few seconds being consumed thereby for the preparation of the patient; instead of making large incisions, the abscess is simply punctured with a strong needle and its contents withdrawn by means of a syringe which aspirates freely: repeated irrigations of the abscess with serum thins the thick pus in the mass so that it can be sucked out through the apex; then pure serum is injected into the abscess, on an average about one-third to one-half the amount represented by the pus removed; the site of the puncture is then covered with a little piece of gauze held in place by adhesive plaster. Only in cases of very marked inflammatory symptoms is a Burrow's vapor dressing recommended.

2. *The healing of the abscess follows quickly and surely.* (The very large and deeply situated abscesses are an exception. See the indications, p. 12.) For the most part, the pain experienced by the patient ceases immediately after puncturing; the fever falls; the inflammatory symptoms, the inflammatory edema, the accompanying lymphangitis, etc., almost always subside by the next day, or else disappear completely by that time.

Hand in hand with the external signs of improvement goes the process of healing inside the abscess. The breaking down of the tissue into pus ceases, the necrotic portions of tissue are separated from sound tissue and at the next puncture can be removed, after thinning the contents of the abscess with serum, or they are removed spontaneously after the formation of fistulae; the contents of the abscess is frequently cloudy or bloody for the first day or two—in the cases of larger abscess we do not get clear, pure serum until a repetition of the puncture is made. The pure serum is proven sterile by a bacteriological examination.

The leucocytes found in the serum show an increase in their phagocytic powers.

3. *The after treatment is simple and economical.*—The tedious and more or less painful changing of bandages as is necessary

after an incision is dispensed with; a simple examination of the patient once or twice afterwards usually suffices.

In more than half of my cases I succeeded with a single puncture; in a third of the cases I had to repeat the puncture once, and only in the cases of the largest abscesses, with a quantity of pus over 100 c.c. was I forced to aspirate from three to five times.

4. *The length of the treatment is very much shorter in most cases, compared with former methods.* The length of the treatment is in direct proportion to the size of the abscess, *i. e.*, to the quantity of pus withdrawn.

The following table shows the average length of time required by treatment according to the amount of pus removed:

Pus content	Treatment
1— 5 c.c. -----	3 days
5—10 c.c. -----	4 days
10—15 c.c. -----	5 days
15—20 c.c. -----	10 days
20—50 c.c. -----	11 days
Over 50 c.c. (up to 1 1-2 liters) -----	

From the above it is evident that the time required by treatment for the smallest and small abscesses (those containing 15 c.c. of pus) is for the most part shortened; in the case of the larger abscesses, the advantage as to time is not so striking, while in the case of those containing much larger quantities of pus (50 c.c. to 100 c.c. and more) the treatment is just as long drawn out as in the earlier methods. We must prove these facts well founded for the purpose of establishing precise indications for the use of the antiferment treatment.

In that connection I shall write a few words concerning the time necessary for a cure. In any event the latter is shortened, although by our closed method of treatment, puncturing the abscess through the soft parts which cover it, we cannot always tell with certainty when the abscess is completely healed from an anatomical standpoint. The subsidence of the clinical symptoms is not a sufficient guide as to the progress of healing inside of the pus cavity.

According to my opinion, there is not as yet any question of an anatomical restitution at the end of the treatment in most cases. However, it may require several days. As an advantage of the closed method of treatment the fact should be considered that most of the patients may pursue their respective occupations without any danger of a relapse, and after the treatment is finished may even await complete restitution of the tissues without being under medical supervision. Continued medical supervision is only necessary so long as local inflammatory symptoms or general symptoms such as fever, acceleration of pulse, etc., exist.

Healing is independent of the kind of bacterial excitants which may be found (staphylococci, streptococci, diplococci, etc.).

5. *The cosmetic result is excellent.* In abscesses of the face and neck, particularly in women, a means of avoiding the disfiguring scar caused by an incision, cannot be too highly commended. Whoever has seen abscesses of this region, the size of plums and even larger, suddenly disappear after a single treatment and without any external sign of an operation, will the more readily appreciate the good points of this method.

6. *The functional result is better for two reasons:*

(a) By the puncture-treatment, a scar formation at the point of incision, and with it the ultimate cicatricial disfiguration is avoided; and (b) the antiferment which is introduced, through its physiological effect, prevents the further progress of the suppurative process, which in itself would lead to a more extensive cicatricial formation.

Almost all of my cases treated with antiferment healed in an ideal manner, without scar formation.

B. The Untoward Effects and Drawbacks of the Method.

As untoward effects and drawbacks of the method I could mention:

(a) The immediate effects in connection with the treatment.

1. *Pain in the neighborhood of the abscess.* This may be avoided by making sure that no irritating preservative has been added to the serum, and also by taking care not to overdistend the abscess by means of too large a quantity of serum.

2. *Headache and vertigo* I observed only once; in 24 hours these symptoms had disappeared.

3. *Chill during treatment* I noticed in three cases; it lasted continuously for some hours, but on the next day the condition was again normal.

4. *Acceleration of pulse.* On one occasion the pulse was accelerated during the entire treatment. N. B.—Serum exanthema or the appearance of anaphylactic symptoms I never observed after the antiferment treatment.

(b) *Troublesome Sequelae Later on in the Treatment.*

1. *Formation of sinuses at the site of the puncture.* This occurred in a fourth of the cases, for the most part several days (usually on the fourth day) after the puncture. Relapses in connection with sinus formation never occurred; all the sinuses closed up spontaneously, most of them within a week.

2. *A continuation of abscess formation in spite of the treatment,* which was correctly carried out, I saw only once. This was in the case of an old, decrepit patient, with a cervical abscess as large as a child's head.

3. *Prolonged absorption of the injected serum* occurs only when an excessive amount of the antiferment solution is injected into the abscess. In case of such a complication, the superfluous serum should simply be withdrawn, remembering, however, that too copious a withdrawal of this serum may lead to a relapse.

It is better to wash out the abscess thoroughly, allowing a little of the serum to remain, than to fill up the abscess with an excessive amount of serum.

4. *Pigmentation of the skin over the abscess* I saw in two cases.

5. *Marked scar formation at the site of injection* I saw once. Both complications lasted for some months. Aside from all of these harmless complications, I never observed any directly harmful influences of the antiferment treatment.

II. In Infiltrating Suppurations.

In infiltrating suppurations with reference especially to the more diffuse suppurative inflammations, whitlow, phlegmon, phleg-

monous mastitis, etc. (16 cases), my observations lead me to the conclusion that a cure in these cases is possible only when the infiltrating process has caused the formation of a circumscribed abscess.

Otherwise the whole advantage of the method consists only in this, that where the serum comes in direct contact with the wound (3), the secretion dries up, the necrotic portions of tissue are outlined in one or two days and the wound soon clears up. Further progress of the process is not limited, however, by serum treatment.

III. In Bone Abscesses.

In bone abscesses (4 cases), after the area affected is exposed and a long continued treatment with serum baths, serum dressings and finally serum injection is instituted lasting for weeks even, nothing other than a clearing up of the soft parts of the wound is accomplished; the process in the bone, however, advances in spite of this, and we are finally forced to a radical procedure.

IV. In Bone Sinuses.

Bone sinuses (5 cases) come under the same head as bone abscesses.

V. Sinuses of the Soft Parts.

Sinuses of the soft parts, (7 cases), especially if they are broad and superficial and are adapted to serum-tamponade, soon show an improvement—that is, a drying up of the secretion and the fistulous tracts are filled with clean granulation tissue. The fact that the method in infiltrating suppurations and bone abscesses does not work well is based naturally on the theoretical principles. The antiferment serum can only be effective where it is brought into direct contact with the wound surface on all sides (Müller), where, in short, the antiferment chemically unites with the proteolytic leucocyte ferment by direct contact. That physical hindrances to this preliminary condition, such as we have in infiltrating suppurations and bone abscesses work against an effective treatment, is obvious.

The Indications for Antiferment Treatment.—If I may be allowed to limit the sphere of usefulness from the observations

which I briefly cited, I would give the special indications for antiferment treatment as follows:

1. *Antiferment treatment is indicated in highly inflamed abscesses of the soft parts, with the following cases excepted:*

(a) In abscesses of excessive size (*i. e.*, excessive distention of the abscess). In abscesses with a content of 50 to 100 c.c of pus, we save nothing in length of time consumed by treatment, in trouble or expense.

(b) In deeply seated abscesses. The site of pointing of such abscesses is often doubtful, and cannot always be determined with certainty from the clinical signs. Our surgical procedure then, however, is only useful when we know the site of pointing. The non-observance of this golden rule may lead to unpleasant surprises. I recall a case of osteomyelitis of the thigh, with most pronounced symptoms, which we treated; a paranephritis, without any local symptoms, constituted the exit of the pus.

(c) Marked weakness of the patient. Here we should lose no time with the antiferment treatment. Especially when the abscess is somewhat larger than the size indicated above and occurs in very old or decrepit persons, a speedy and free incision is more advisable.

(d) Inflammatory tuberculous abscesses are more suitably treated by incision. In all other cases of abscesses of the soft parts, the antiferment treatment constitutes an ambulatory procedure par excellence.

2. *Antiferment treatment is indicated in infiltrating supplicative processes when the original diffuse process has led to circumscribed pus, i. e., and abscess.*

In all other cases of infiltrating suppurations, the antiferment treatment is without avail, since it does not prevent the advance of the process itself.

3. *The method is indicated in the treatment of sinuses of the soft parts. The secretion stops, the fistulae are filled with clean granulations and the subjective symptoms of the patient are appreciably improved.*

The Extension of the Antiferment Treatment to other fields of Surgery and to allied conditions.—With the observance of this in-

dication, the antiferment treatment may be extended to various fields of surgery.

Beside the usual treatment of subcutaneous abscesses, abscesses of lymph glands and mastitis, I tried the method in other special fields of surgery. It was successful in abscesses of the tongue (2 cases), in inflammatory swelling of the gums (4 cases), in peritonsillar abscesses (8 cases), in buboes (6 cases), in para-rectal abscesses (3 cases), etc.

Kolatzek (Tübingen) has just recently alluded also in an experimental way to the extension of the method to suppurative conditions of the internal organs (38th Congress of the German Society of Surgeons, Berlin, 1909). He considered suppurations of the body cavities (meningitis, pyothorax, and finally pericarditis purulenta), suppurations of bursae, of the joints, suppurative inflammations of the urinary passages etc. Unfortunately I am still lacking in sufficient experiences to give an opinion here. I can only second the words of Müller when he says: "More general work is needed in order to study more exactly the good and the bad points of antiferment treatment."

The antiferment treatment has also proven efficacious in still other fields. Lenz (Breslau) tried the method in eye diseases. A. Fuchs (Breslau) reported some favorable experiences with it in gynecological work. At all events, my experiences with abscesses of the tongue, gum abscesses, peritonsillar abscesses and buboes point favorably to an extension of the method to the fields of stomatology, laryngology and urology.

Attempts to Replace the Antiferment Treatment by Other Means.—A further question of practical significance might be whether or not it is possible to replace the antiferment treatment by other methods and the antiferment sera by other solutions.

Simple puncturing will give results only in quite small abscesses (those having a pus content of 1 to 2 c.c.). This, however, fails sometimes.

A physiological salt solution (0.9 per cent) harms rather than helps; especially the injection of very large quantities of salt solution often leads to the appearance of unfavorable symptoms. I saw better results in the treatment with salt solution when I added

calcium chloride in minimum quantities (0.001 to 0.01 per cent). This is explained theoretically by Hamburger and Heckma, who claim that the addition of minimum quantities of calcium ions enhances the phagocytic action of physiological salt solution considerably.

Likewise the addition of calcium chloride seems to arrest the toxic action of salt as a cell poison (Loeb).

The injection of animal sera (horse serum, beef serum) is accompanied by extremely violent reactive manifestations. Hand in hand with the latter we have an active hyperleucocytosis and an increase in phagocytic protective power, as is proven by the extensive trials of Fejes (Budapest).

I tried animal serum in over 100 cases of suppurative processes and finally succeeded in arriving at a dose for its clinical effect. A simple washing out of the abscess with serum suffices to bring about that degree of hyperleucocytosis which is necessary to a cure of the abscess, by retarding the excessively violent reactive symptoms. If one wishes more pronounced inflammatory signs, filling the abscess with just a few cubic centimeters of animal serum (1 to 5 c.c.) is indicated.

The larger doses of animal serum are employed in the treatment of tuberculous processes.

In surgery, the physiological treatment of suppurative processes is not new. Recently it has been brought forward by Mikulicz with his nucleinic acid treatment and Bier with his hyperaemic treatment. To these methods are linked the antiferment processes of Müller, Kolaczek and Peiser; also the treatment of suppuration with physiological solutions and animal sera, which I have just mentioned briefly, belong here.

With all of these methods, however, there is something in common. They are not similar in all respects to the physiological preventive measures, but only in one or the other of their chief manifestations. However, they cannot be otherwise at this time. A truly ideal method for all cases of surgical suppuration has not yet been given nor will it be given until the chaos of our present views concerning the natural protective agents of the organism is dispelled, until the smallest details of the processes

of protection against infection are completely understood—in a word, not until we thoroughly grasp the complicated workings of physiological protective measures in all their phases. On these grounds only will we be in position to effectively support the natural curative forces in all cases of surgical infection.

That would be the ideal method of physiological treatment! At present it is only prospective—still, such a treatment may be arrived at by means of most extensive and searching attempts at physiological wound treatment. Our way, therefore, seems to be right. Directed in our course anew by the work of Edward Müller, his service to us is everlasting.

PERIPHERAL NEUROSIS DUE TO TOBACCO.

Von FrankHochwart first mentions cases of neuralgia, due evidently to excessive smoking. He has notes of thirty-one cases of sciatica and twenty-two of brachial neuralgia. Diffuse pains, not restricted to individual nerve areas, were represented by 110 cases. The nature of these latter is obscure, as in some cases an arthropathy seemed to be present. In regard to a nicotine polyneuritis one must be noncommittal. The author has seen four cases in heavy smokers which could not have been due to alcohol or lues. A few cases have been reported by others. The condition termed by Erb *dyskinesia intermittens angiosclerotica* is abundantly recognized by its sponsor as occurring much more frequently in heavy smokers than in any other class of people. It is very largely a tobacco angioneurosis. The tremor and fibrillary twitching due to tobacco are well known. The nervous visceral affections due to nicotine comprise first of all cardiac irregularities of all kinds—palpitation, arrhythmia, pseudoangina pectoris. Respiratory phenomena of the same origin include dyspnea and Cheyne-Stokes breathing. There is possibly such an affection as pseudoexophthalmic goiter due to tobacco poisoning. The dyspepsia, loose bowels, and constipation due to tobacco are nervous in type. Tobacco is known to favor nocturnal pollutions and premature ejaculation, while many heavy smokers are more or less impotent.—*Medical Record*.

URGENT SURGICAL LESIONS WITHIN THE ABDOMEN, WITH SPECIAL REFERENCE TO DIAGNOSIS.

BY H. HORACE GRANT, A.M., MD., *Louisville, Ky.*

The object of this paper is to present a few important clinical facts well known to a surgeon in active practice, and yet with which, as a rule, the average physician is not unduly familiar. In urgent surgical lesions of the abdomen, the meaning and significance of diagnosis to the attendant is not so much the classification of the disease from which the patient may be suffering, as determination of what the situation actually demands.

Considering the well-nigh perfect surgical technic of the present day, it is almost an open book what should be done after a correct diagnosis has been made, and consequently more than ever before the value of surgery hinges upon promptness, together with accuracy of the mental picture of the pathological lesion or lesions present.

There are four acute lesions within the abdomen to which attention is especially directed, because, in the writer's judgment, all demand surgical intervention as soon as recognized. These are, in the order of their frequency (1) fulminating appendicitis, (2) intestinal obstruction, including strangulated hernia, (3) extra-uterine pregnancy, and (4) intestinal perforation.

At the bedside of every seriously ill patient, the most important question to the attendant is not always the nature of the disease with which he is confronted, but what can be immediately accomplished looking toward relief of the patient. And when the exact pathology cannot be definitely determined within the time limit of safety, the attendant must understand that his duty is to invoke aid in the remedy suitable to the class to which the symptoms belong. If the intelligent application of surgery be too

long delayed by searching for the specific pathology in cases demanding treatment, it may then be too late to be of benefit to the patient; in other words, the practical feature of diagnosis under such circumstances is to determine: "Do the symptoms present justify the conclusion that the case belongs to the group demanding prompt surgical intervention?" Practically speaking, the lesions included in this group lead to death by one of two avenues—peritonitis or sepsis—usually by both; and, as a matter of fact, nothing can prevent these developments except prompt surgical action. It is true, however, that a patient with appendicitis, even the most threatening form of this treacherous disease, will sometimes go on to recovery without operation.

APPENDICITIS.

Nearly every physician is presumed to be familiar with the classical symptoms of surgical appendicitis, and, in the light of present knowledge, there is rarely any doubt as to the diagnosis. The colicky pain which develops early, attended by vomiting, constipation, elevation of the temperature, and localized tenderness over the characteristic area, furnish a typical mental picture of an inflamed appendix, which has induced (a) arrested peristalsis and colic, (b) reflex vomiting and inactivity of the intestines, and (c) when the reflex action subsides, colic is superseded by localized tenderness over the site of the lesion.

The local symptoms are often proportionately more severe in the earlier stage of the disease than the pulse and temperature of the patient would appear to indicate. However, the pulse ordinarily increases numerically in ratio with pain and functional distress. The temperature is variable, and while there is always some elevation, until infection becomes constitutional, it may not be high.

With such a picture before him, the attendant must say to himself: "If this continues twenty-four hours without improvement, local infection of the peritoneum is certain, while abscess, gangrene and perforation constitute dangers, the probabilities of which are absolutely undeterminable." Previous to perforation,

the symptoms of appendicitis are distinct, but thereafter they may be included in a group to be described later.

If the diagnosis be made before perforation, the invocation of surgery will insure recovery of the patient in 90 per cent of even grave cases, and the diagnosis may be safely based solely upon localized tenderness to pressure at McBurney's point and elevation of temperature, with or without the presence of the other symptoms noted. In children, less confidence can be placed on local tenderness, although by careful investigation a tender point can usually be determined. However, in children, the evidence of natural distress, *i. e.*, pain, vomiting, etc., are more notable proportionately.

The symptoms detailed characterize the early stage of the variety of appendicitis demanding prompt surgical attention, and, in the hands of the experienced surgeon, the mortality is less than 10 per cent. In the judgment of the writer, operation is advisable in any stage of appendicitis as soon as the diagnosis is made.

INTESTINAL OBSTRUCTION.

In so-called dynamic or mechanical obstruction of the intestine from strangulation by bands, hernia, intussusception, or volvulus, particularly when the obstruction is complete, the mental picture before the attendant must not be one simply of obstruction of the fecal overflow, which is of no serious import, but arrested circulation in a highly vascular structure, with the certainty of local death of the part, sepsis and peritonitis, exhaustion and death; and he must understand that the mechanism causing the obstruction will be aggravated by the application of any force from above, and will likewise resist any force from below; that every hour of delay represents a march of the destructive process toward certain dissolution of the patient.

The diagnosis must be made promptly, for relief in all cases of intestinal obstruction should be obtained during the first twenty-four hours, *i. e.*, before peritonitis supervenes. In external strangulation of the intestines due to hernia the diagnosis can be made at a glance, and no time should be lost in preparing the

patient for operation where the hernia is not easily reducible by taxis.

It may seem an unnecessary expenditure of words to describe the treatment of strangulated hernia, but any one who thinks so over-estimates the general rank and file of the profession. In some quarters, for instance, as a result of delay, prolonged taxis, injections, poulticing, etc., it happens that every day of the world curable patients are permitted to perish.

The four cardinal symptoms of intestinal obstruction are: (a) obstipation, (b) colicky pain, (c) vomiting and (d) distention. When confronted with these symptoms, which usually rapidly succeed each other, the attendant should refrain, as far as possible, from undertaking treatment until he has made a satisfactory diagnosis. It is most important that no attempt at purgation be made. The attendant must remember this axiom, that if the condition be intestinal obstruction, purgation will do no harm, and if it be not obstruction, enemata will sooner or later induce relief. Morphine, administered to alleviate pain, may mask the symptoms, and thus delay diagnosis. Gastric lavage to relieve vomiting, while inducing general comfort, should be withheld until the case has been well studied. These precautions are important, and their observance should not be neglected. If an enema (preferably equal parts of milk and molasses) fails to bring about positive results (fecal matter and gas), vomiting and distention persisting, unrelieved, with temperature normal or slightly below, the pulse being little affected during the first twenty-four hours, the diagnosis is "making itself."

In children, particularly, straining at stool may be followed by the passage of mucus and blood, but no fecal matter or gas will escape in complete obstruction. In using enemata, care must be exercised to admit no air with the syringe. Of course, the surgeon will explore all the hernial regions, and systematically palpate the abdomen for the sausage-like tumor of intussusception. The abdominal tympanites corresponds to the site of the obstruction, and if that be high in the abdomen, vomiting is earlier and more troublesome, and the distention is less. It not infrequently happens that the colicky pains become greatly lessened,

and often cease altogether as the intestine loses its vitality. The gurgling and borborygmus which mark the first stage of obstruction also cease as peritonitis develops, and the vomiting is superseded by eructations and hiccough. The pulse increases in frequency and feebleness, and after a variable period collapse appears, with clammy skin and Hippocratic countenance, representing a hopeless condition. The situation of the constriction and the degree of distention, together with the age of the patient and the vigor of his constitution, determine the period over which the symptoms may extend. Usually forty-eight to sixty hours represent the limit in internal strangulation, while the condition rapidly becomes less promising after the first twenty-four hours.

The expectant treatment in all forms of intestinal obstruction should be limited to a few well-directed enemata. No effort at purgation is to be entertained for a moment, and everything should be "hands off" until preparations are made for surgical exploration. No words should be wasted on differential diagnosis. The progressive symptoms noted mean death of the patient if not promptly relieved, and they belong to the group demanding exploratory surgery. After twenty-four hours the prospect of relief by the invocation of surgery becomes less and less hopeful.

ECTOPIC PREGNANCY.

Ruptured ectopic pregnancy, like the two preceding emergencies, presents some special features of diagnosis. It is most commonly encountered in women given a history of previous pelvic trouble, after one, or perhaps, two menstrual periods have been missed. Often the first symptom noticed is an irregular metrorrhagia, and pregnancy may or may not have been suspected, but menstrual irregularities are the rule.

Any one of several terminations may accrue as a result of ectopic pregnancy. However, the diagnosis is unmistakable where there exists a history such as that noted, and where the patient has a sudden lancinating pain in the ovarian region, followed by great depression, pallor, feeble pulse and collapse, from which there may be either reaction or syncope and death in a few hours. If reaction follows and the character of the pulse improves, vaginal examination after eight or ten hours will reveal

a mass in the ovarian region painful to touch, pushing the uterus to the opposite side, and re-examination will show increase in size of the mass during the first forty-eight hours. This physical manifestation following the history noted, leaves no doubt as to the diagnosis, and indicates the immediate necessity for operation, as no judgment can foretell when hemorrhage will recur. Operative intervention during the period of collapse should only be undertaken in the best surroundings, and with the understanding that there is little hope either way. Operation after reaction insures an almost certain recovery where infection can be avoided.

INTESTINAL PERFORATION.

While the three lesions mentioned usually present sufficient characteristic symptoms to be differentiated, this is not always true, and they must be considered among the possibilities when surgically exploring for conditions producing the group of symptoms to which repeated allusions have been made. In this group experience has led the writer to include, in addition to the vagaries of appendicitis, intestinal obstruction, etc., *perforation of the intestine or stomach, whether from gastric, duodenal or typhoid ulcer, rupture of an internal abscess, extensive suppuration about the bile passages, and acute pancreatitis.*

In intestinal perforation the first symptoms are much like those due to rupture of an ectopic gestation, except pain is distributed over the abdomen, and collapse is less severe. More or less complete reaction takes place in a few hours, though pain becomes more severe, the temperature rises, vomiting, constipation, increasing distention, and all the symptoms of acute peritonitis supervene within twenty-four hours. Fatal attacks of this character, in which the patient does not react, are called "fatal acute indigestion," the pathological lesion not being recognized. Sudden pain and shock, followed by reaction from the latter, but steadily increasing abdominal discomfort, almost always accompanied by elevation of temperature, indicate intestinal or gastric perforation, the abdominal symptoms being due to beginning peritonitis. The location of the original pain-point in

a measure is an indication as to site of the perforation, but is too indefinite to be of much importance.

In acute pancreatitis the symptoms are similar to those of intestinal perforation during the first twenty-four hours, and the condition is likewise difficult to distinguish from intestinal obstruction, the early peritonitis locking the bowels. Location of the tenderness and the profound shock may strongly indicate a lesion of the pancreas, *i. e.*, pain in the left hypochondrium, with tenderness over the region of the pancreas. The diagnosis oftentimes cannot positively be made in the first stage. If, after thirty-six hours, the symptoms subside and induration can be demonstrated in the pancreatic region, the likelihood of a deposit of blood and threatened abscess formation is to be considered. However, these symptoms are so positively in the dangerous group that all haste should be made toward surgical exploration under suitable surroundings.

In suppuration of the bile passages there is usually a history of previous gallstone colic, or catarrh of the bile passages. An attack of pain in the upper right side of the abdomen, accompanied by chill, high temperature, constipation, vomiting and marked tenderness over the characteristic region, indicates a gall-bladder lesion. The temperature is especially diagnostic, and, considered in connection with the previous history, will sometimes make diagnosis easy.

In perforation of chronic ulcer of the stomach or duodenum, there is always a history of previous gastric disturbance, and other symptoms, pain, etc., in relation to the ingestion of food, as well as chronic soreness and tenderness on pressure. These symptoms, preceding the shock described as indicating intestinal perforation, will make the diagnosis almost certain. When the indications of perforation have for a long time been preceded by symptoms vague, but suggestive of hepatic or sub-diaphragmatic abscess, the diagnosis is more confidently settled. However, even in the absence of distinctive symptoms, the surgeon being confronted with those belonging to the dangerous group, exploratory celiotomy is to be urgently advised. The differential diagnosis is based upon the presence of symptoms indicating grave lesions,

whether possessing the characteristics of appendicitis, intestinal obstruction, acute pelvic lesions, or the still more pronounced shock and progressive depression incident to intra-peritoneal rupture of ectopic gestation or the intestines.

In the consideration of these general symptoms, the attendant has really only to exclude functional conditions, such as hepatic, nephritic, and intestinal colic. These functional disturbances oftentimes produce severe pain, vomiting and not infrequently constipation. However, there is rarely any shock, temperature remains normal, and the pulse but little accelerated, while the character and location of the pain constitute a safe guide. Ordinarily in the course of a few hours these functional conditions can be excluded, and the attendant will then realize that he has had under observation a patient suffering from a lesion with symptoms belonging to the dangerous group.

In conclusion, the writer urges that two fundamental facts which he has seen demonstrated over and over again be constantly borne in mind, viz.:

1. That the trained and experienced judgment of the surgeon will oftentimes save life in surgical emergencies even where the conditions appear almost hopeless.

2. That skillfully executed exploratory celiotomy, even in the presence of the most threatening conditions, adds little to the danger and oftentimes offers great promise as to preservation of the life of the patient.—*The Louisville Monthly Journal*.

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at \$1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Sumner and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

SUBSCRIPTIONS AND PREMIUMS.

That sterling medical journal, the *Texas Medical Journal*, in "Notes and Miscellany," has the following query: "Doctor, in case you sent your bill to a patron repeatedly, for several years' service and he paid no attention to it—ignored it, what would you do? Say a small amount (like a subscription to the "Red Back" for instance), do you think he would be treating you just right?"

Two men at a saloon bar taking a drink. The treater, wishing his co-drinker the best of health, accentuates his good wishes with a courteous bow. The treated, at a loss for something better to say, responds with the words, "I bows likewise," and proceeds to quaff. To the sentiment implied in the above extract we also say, "I bows likewise." The JOURNAL with its last issue mailed statements of accounts for subscription to all in arrears. Despite the fact that an elegant premium has been offered to every one who pays up his subscription, only a few as yet have taken advantage of the offer, and our supply of thermometers thus offered is still plentiful. As a rule, doctors are the most courteous and honorable of men. Is there any good reason why the same rule of life they observe in other transactions of business should not be observed in the relations between publisher and subscriber? Surely there can be no palliation of such flagrant neglect. Surely such demands deserve at least a reply—a notification at least that the JOURNAL should no longer be sent or at least a promise to pay up in a reasonable length of time

and an order to continue the subscription. We are adding daily new names to our mailing list, and shall drop those who do not reply from the same unless some kind of response is made in a short time.

We hope every one who reads this will appreciate our position and lose no time in sending in their subscriptions and renewals. Let us hear from you without delay.

PROGRAM OF AMERICAN PROCTOLOGIC SOCIETY, FOURTEENTH ANNUAL MEETING, ATLANTIC CITY, N. J., COMMENCING MONDAY, JUNE 3, 1912.

Executive Council meets at 11 a.m.

First regular session at 2 p.m.

Annual address of the President—Subject: "The Relationship and the Duties of the Proctologist to the Profession," John L. Jelks, Memphis, Tenn.

PAPERS.

1. "A Review of Proctologic Literature for 1911," Samuel T. Earle, Baltimore, Md.

2. "Post-Operative Care of Rectal Cases," Wm. M. Beach, Pittsburgh, Pa.

3. "Patulous Anus—Its Clinical Significance," Alfred J. Zobel, San Francisco, Cal.

4. "The Three-Step Operation in Tumors of the Sigmoid and Colon," James P. Tuttle, New York City, N. Y.

5. "A Study of Cases of Constipation by the Use of the Roentgen Ray," Arthur F. Holding, New York City, N. Y.

6. "Valvotomy," George B. Evans, Dayton, Ohio.

7. "Multiple Adenomata of the Rectum. A Report of a Case with Symptomatic Relief by Simple Remedies," E. H. Terrell, Richmond, Va.

8. "Pigmentation of the Rectum and Sigmoid," Jerome M. Lynch, New York City, N. Y.

9. "Observations Upon the Relationship of Tuberculosis to Peri-Rectal Suppurations," Collier F. Martin, Philadelphia, Pa.

10. "Ano-Rectal Disease Due to Venereal Infection," J. A. McVeigh, Detroit, Mich.
11. "Further Observations on Pruritis Ani: Its Probable Etiologic Factor," Dwight H. Murray, Syracuse, N. Y.
12. "Colonic Dilation (Congenital and Acquired) as a Factor in Chronic Intestinal Obstruction (Obstipation)," Samuel G. Gant, New York City.
13. "Acute Post-Operative Intestinal Paresis," J. A. McMillan, Detroit, Mich.
14. "Prevention and Treatment of Post-Operative Retention of Urine," Frank C. Yeomans, New York City, N. Y.
15. "Intra-Rectal Rupture of Suppurating Sinus from Hip-Joint Disease," Ralph W. Jackson, Fall River, Mass.
16. "(a) Keloidal Tuberculoma; (b) Fibromatous Keloid," Alois B. Graham, Indianapolis, Ind.
17. "Differential Diagnosis of Ulcers of the Rectum," Leon Straus, St. Louis, Mo.
18. "The Surgery of Colonic Obstipation," Louis J. Hirschman, Detroit, Mich.
19. "Rectal Carcinoma," J. Rawson Pennington, Chicago, Ill.
20. "Reflex Disturbances Referable to the Rectum," T. Chittenden Hill, Boston, Mass.
21. "Some Practical Points Gleaned from the Observations of a Proctologist," Samuel T. Earle, Baltimore, Md.
22. "Some Practical Considerations of the Etiology of Diarrhea and Its Treatment," J. Coles Brick, Philadelphia, Pa.
23. "Venereal Affections of the Anus and Rectum," Edward A. Hamilton, Columbus, Ohio.

DENTAL INTERNE (MALE), GOVERNMENT HOSPITAL FOR THE INSANE, JUNE 5, 1912.

The United States Civil Service Commission announces an examination on June 5, 1912, at the places mentioned in the list printed hereon, to serve eligibles from which to make certification to fill a vacancy in the position of dental interne (male), at \$600 per annum, with maintenance, in the Government Hospital for the Insane, Washington, D. C., and vacancies requiring sim-

ilar qualifications as they may occur, unless it shall be decided in the interest of the service to fill such vacancy by reinstatement, transfer or promotion.

The Department states that it reserves the right to terminate the appointment at the expiration of one year of service if it is deemed advisable to do so.

The examination will consist of the subjects mentioned below, weighted as indicated:

<i>Subjects</i>	<i>Weights</i>
1. Letter writing (the subject matter on a topic relative to the practice of dentistry) -----	5
2. Anatomy and physiology (general questions on these branches, also with special reference to the teeth, mouth, and head) -----	10
3. Chemistry, materia medica, and therapeutics (the preparation, properties, and reactions of chemicals; crude drugs and their action and application, with those of other therapeutic agencies) -----	15
4. Dental pathology and oral surgery (the morbid processes incident to diseases and injuries of the teeth, mouth, and contingent structures, and their surgical treatment) -----	20
5. Operative and prosthetic dentistry (the detailed technics of general and special operative and laboratory work) ---	25
6. Bacteriology, histology, and hygiene (the cultivation, isolation, demonstration of bacteria, the principles of sterilization, mounting specimens, use of microscope, the principles of general and oral hygiene, etc.) -----	10
7. Orthodontia (local and constitutional irregularities in growth and development of the teeth, and their correction) -----	15
Total -----	100

Applications will not be accepted from persons who fail to indicate, in answer to Question 18 of the application form, that they are graduates of not more than 18 months' standing of regularly incorporated dental colleges.

Applicants must be unmarried.

Age limit, 20 years or over on the date of the examination.

This examination is open to all citizens of the United States who comply with the requirements.

This announcement contains all information which is communicated to applicants regarding the scope of the examination, the vacancy or vacancies to be filled, and the qualifications required.

Applicants should at once apply either to the United States Civil Service Commission, Washington, D. C., or to the secretary of the board of examiners at any place mentioned in the list printed hereon, for application and examination Form 1312. No application will be accepted unless properly executed and filed with the Commission at Washington. In applying for this examination the exact title as given at the head of this announcement should be used in the application.

As examination papers are shipped direct from the Commission to the places of examination, it is necessary that applications be received in ample time to arrange for the examination desired at the place indicated by the applicant. The Commission will therefore arrange to examine any applicant whose application is received in time to permit the shipment of the necessary papers.

Issued May 2, 1912.

GREATER NEW YORK NUMBER.

In June the American Journal of Surgery will issue a number composed of original contributions from men of recognized prominence in the medical profession residing in greater New York. Among those to contribute are: Herman J. Boldt, C. N. Dowd, Meddaugh, Dunning, Wm. S. Gottheil, E. L. Keys, Jr., Howard Lilienthal, Chas. H. May, Willy Meyer, Robt. T. Morris, S. Lewis Pilcher, John O. Polak, James P. Tuttle, James P. Warbasse and others. Contributions from these well known men should make this issue of particular interest and value.

OBITUARY—DR. JAMES B. MURFREE.

After a lingering illness of several months, Dr. James B. Murfree died at his home in Murfreesboro, Tenn., at 10 o'clock, April 24, at the age of 77 years. While his death had not been unexpected, still the blow came with powerful force to the community in which he had long practiced and by every member of whom he was well known. No man ever worked harder or more earnestly in the discharge of his duties, and doubtless his long and strenuous life contributed not a little to his decease. Death thus has removed from the profession in Tennessee one of its most conspicuous figures. Dr. Murfree towered in talents, as in figure, head and shoulders above his fellows, and invariably challenged the attention of all with whom he was brought in contact. His devotion to his work was almost phenomenal. He was never known to refuse a call, and was as assiduous to the poor as to the rich. His life was a continuous one of self-denial and sacrifice. He lived for the good he could do—not for the good he could get. His character was unblemished, his honor and integrity beyond cavil, his religion sincere. In his dealings with his fellows in medicine he was courteous, dignified and always ethical. In the medical gatherings, which he was fond of attending, he was a prominent figure, and his papers and discussions were always received with the attention and appreciation they always deserved. The death of Dr. Murfree is a distinct loss to the profession of the State. He was an example of all that is admirable and lovable in the medical man. The high positions he occupied in the profession to which he devoted his life were owing to his earnestness, his faith and his unflagging industry. He was beloved by all who knew him, by none more than by his *confreres* with whom he was brought in contact. The writer of this imperfect sketch can never forget the kind friendship of this great and good man, and feels that nothing he can say could add anything to the reputation this great man has left behind. Dr. Murfree was a great man, whose memory the profession will always be glad to honor. We append a short sketch of his life from the daily press.

“Dr. Murfree was the oldest and most prominent physician and

surgeon in Murfreesboro and Rutherford County. When it was intended by the general public to emphasize the perfect popularity of a person, it was a common expression to say, 'He was as popular as Dr. Murfree.' That was considered the acme of personal and professional praise.

"Dr. Murfree was a native of Rutherford County, born September 16, 1835, a son of M. B. and Mary A (Roberts) Murfree, both of whom were of North Carolina nativity. He was a grandson of that Revolutionary hero and patriot, Col. Hardy Murfree, in whose honor the city of Murfreesboro was named. Dr. Murfree received his education at Union University, one of the oldest institutions of the South, and received the degree of A.M. In the summer of 1856 he began the study of medicine, and in October, 1856, he entered the Medical Department of the University of Nashville. In 1857 he took two courses of lectures in Jefferson College, Philadelphia. He graduated from that institution in March, 1859, with the degree of M.D. He then returned to Murfreesboro and practiced his profession till the breaking out of the Civil War, when he enlisted in the First Tennessee, Company I, and served as a private till June, when he was appointed surgeon and was later commissioned as assistant surgeon of the Confederate army. After the surrender he returned to Murfreesboro and resumed the practice of his profession, which he continued with remarkable success up to the time of his last illness.

'Dr. Murfree was always, or since the Civil War, a 'straight Democrat;' he served the municipality of Murfreesboro for two terms as Mayor. He had been a leading member of the Presbyterian Church and a deacon in the church for many years. In the early 60's he was married to Miss Ada J. Talley, a native of this county, and a daughter of Maj. P. C. Talley, of Readyville. To this union was born nine children, six of whom, with his wife, survive. Although Dr. Murfree had been in delicate health for about two years, so great was the confidence reposed in him by his patients and the public as a physician, he was not allowed to give up active practice till his physical condition precluded the possibility of his leaving his home, and even up to the end trust-

ing patients insisted on him prescribing for them in their illness.

"Dr. Murfree would have been 77 years of age next September. His remains will be laid to rest in the family plot in Evergreen Cemetery."

ACTION OF THE MIDDLE TENNESSEE MEDICAL SOCIETY.

Resolutions of respect on the death of Dr. J. B. Murfree:

Inasmuch as God in his infinite love and mercy has seen fit to remove by death our venerable and highly esteemed membr, Dr. J. B. Murfree, we feel that we have lost a valuable member and brother; his courteous and pleasant disposition always brought interest and sunshine into the meetings of the Middle Tennessee Medical Association; therefore be it

Resolved, That we bow in humble submission to this dispensation of divine law; that we sympathize with his family in their irreparable loss, and commend them to the care of him who doeth all things well; and be it further

Resolved, That these resolutions be made a part of the proceedings of this society and spread on the minutes of this meeting; that the Secretary be instructed to send a copy to his family and also to his local medical society.

W. K. SHEDDAN,
S. T. HARDISON,
B. F. FYKE,
Committee.

Pulaski, Tenn., May 16, 1912.

Reviews and Book Notices

Thornton's Medical Pocket Formulary. New (10th edition. Containing over 2,000 prescriptions, with indications for their use. In one leather-bound volume. Price, \$1.50, net. Lea & Febiger, Publishers, Philadelphia and New York, 1912.

The fact that this pocket reference book has gone through ten editions is ample evidence of its popularity. The author has in this book presented the collective experiences of the medical profession as to the most efficient means of combatting disease. For each disease, arranged in alphabetical order, are given selected formulæ, with quantities, both in the ordinary and in the metric systems. The most experienced physician will find it useful as a reminder, and the younger practitioner will perform his duty better to his patient and to himself by reference to these selected formulae. The indications and annotations employed will be found useful.

Municipal Ordinances, Rules and Regulations Pertaining to Public Hygiene. Adopted from January 1, 1910, to June 30, 1911, by cities of the United States having a population of over 25,000 in 1910.

This is a valuable publication for health authorities of the country and for all interested in the subject. It is a systematic compilation of changes and advances in the sanitation of cities of the United States as shown by the adoption of new ordinances and the amendments and alterations of old laws of hygiene and sanitary perfection as in force by Health Boards for the safeguarding of public health. The reports incorporated herein are from cities of the United States having a population of over 25,000, and extend as far back as January 1, 1910. As a comprehensive report of all recent advances in sanitary medicine this publication will prove of great interest and value to health officers and health boards.

The Surgical Clinics of John B. Murphy, M. D., at Mercy Hospital. Chicago. Vol. 1, No. 2. Octavo of 291 pages, illustrated. Philadelphia and London. W. B. Saunders Company, 1912. Published bi-monthly. Price.

per year, paper, \$8.00; cloth, \$12.00. W. B. Saunders Company, Philadelphia and London.

The second volume of this bi-monthly publication has just been received and reviewed. As might be expected, there are fewer errors than in the first number. This volume is replete with clinics dealing with bone and joint surgery, and since Murphy is working along original lines in this branch of surgery, all these articles are rich in originality. In all there are nineteen clinical reports, which take up, besides the bone and joint surgery, tumors, syphilis, nerve anastomoses, plastic operations, intestinal surgery and tendon operations. We take great pleasure in recommending this bi-monthly publication to our subscribers, whether they do surgery or not. There is much valuable reading matter for the internist as well as for the surgeon.

The Treatment of Shortsight. By Prof. Dr. J. Hirschberg, Geh. Med. Rat. in Berlin. Translated by G. Lindsay Johnson, M. D., F. R. C. S., with Twelve Illustrations. New York. Rebman Company, 112-3 Broadway.

This monograph is a lecture on the treatment of shortsight, published recently in his German clinic. It is a very valuable guide on the subject, and will prove of the greatest advantage to specialists and practitioners. The author's extended experience in the practice of ophthalmology renders this treatise of especial value to every one interested in this common affection, particularly to specialists who have to deal with this class of affections.

Publisher's Department

"Both in my practice in New York City and particularly during the summer, when I am located at Richfield Springs, N. Y., a resort where thousands of rheumatic and gouty patients take the sulphur baths, I have prescribed Tongaline extensively, and it has always proved most satisfactory."

"I would state that owing to the care and skill used in its manufacture, as also because it is always uniform and is well borne by the stomach, Tongaline stands foremost among the ready-made prescriptions for rheumatism, neuralgia, grippe, gout, etc. Besides the conscientious practitioner hesitates about having such a complicated prescription as Tongaline prepared by a pharmacist, because even if the latter had fresh and pure ingredients, he has not the facilities to compound them properly nor could he do so in any reasonable time."

"Robinson's Elixir Paraldehyd." 10 per cent. Paraldehyd is hypnotic and anodyne. It calms restlessness and insomnia, and procures unbroken sleep from four to seven hours' duration, and to leave behind neither languor, nausea nor digestive disorders. It also acts as a diuretic. It has been found efficient in the insomnia of various acute diseases, and also in acute mania. It is proposed as possessing the good without the evil qualities of chloral. (Nat. Dis., 3rd Edit., p. 151.) Robinson-Pettet Co., incorporated. (See page —, this issue.)

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NASHVILLE JOURNAL — OF — MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

VOL. CVI.

JUNE, 1912.

No. 6.

Original Communications

REPORT OF CASE. ABDOMINAL CAESEREAN SECTION.*

BY CHARLES R. WRIGHT, M.D., Pulaski, Tenn.

An operation of choice, when the life of the child or mother is in danger, by not being able to deliver by the vaginal route.

Unfortunately at the present time, it is usually what it should not be, viz.: an emergency operation.

In our rural location, with no hospital at hand, we must not attempt the sending of such cases to the well-equipped institutions of our distant cities, for, by so doing, we are procrastinating, and the thief of time often carries our patient to the "Silent Beyond."

On the morning of March 14, 1912, at 6:30 a.m., I was called as consultant physician and surgeon in this case.

Case L. F.—White, age 24 years and first child. As a child, she had many diseases common to children. One sister died of dropsy. Two brothers, father and mother are living and in good health. She and her family physician report that during the last few weeks of her pregnancy her feet and legs were swollen well to the knees, and her abdomen well enlarged, which misled her friends and family from thinking she was pregnant. After an examination by me, the family was informed of her condition and medical treatment instituted. She was in convulsions. The

*Read before the Middle Tennessee Medical Association, Pulaski, Tennessee, May 16, 1912.

convulsions continued to increase in frequency and severity—at first about thirty minutes, and in a few hours as often as every fifteen or twenty minutes.

At 10:30 a.m., I decided to try to deliver the child, and called a nurse for the case. The patient was chloroformed and placed on a table in the kitchen. Dilation of the cervix was tried for an hour and forty minutes, but the cervix could be dilated only after much force, and when the fingers were inserted to assist, it would contract down so that I had to go back to instrumental dilation time and again. It was then that the Caesarean section appeared to be the only means by which the life of the mother or child, one or both, might be saved, for the unborn infant continued to give signs of life by movements after a slight convulsion of the mother under the anesthetic.

To do the vaginal Caesarean section through a vagina that had not been warned by nature what was to come through it, and no relaxation in any of its parts, would be criminal for the laceration it would cause the mother, and the amount of repair it would necessitate. The abdomen, which had held this pregnant uterus for these many weeks of pregnancy offered me a much better route, and one that could be handled with more ease.

The position of the fetus having been previously made out as correctly as possible, and by knowing this, it was a point of value when I made the uterine incision.

The incision of the abdomen was in the median line, and down to within an inch and a half of the bladder, and about three inches above the umbilicus. The bleeding from the abdominal walls was "nil." As I was making my abdominal incision, through the abdomen, it was done with the utmost care. When the abdominal incision was large enough, I drew the uterus out upon the abdominal walls in order to open it. I packed around it such sterile towels as I had at hand, for fear something might happen which would infect and give trouble. I could not tell how clean the case was, upon which I was operating; therefore, to be on the safe side, I drew the uterus out upon the abdomen. In opening the uterus, two lines of incision presented themselves. One was by a transverse incision over the fundus, parallel to the course of the ovarian blood vessels. The other was a longitudinal in-

cision from the fundus toward the cervix, which in every respect is a classical incision, and was done in this case. The amount of blood lost from the uterine incision was less than two pints.

The position of the child in the uterus governed the way in which it was taken out, i.e., in the vertex presentation, the feet and buttock was the first to come out through the uterine incision. When the child was delivered, I turned it over to my anesthetist, Dr. E. C. Freeman, and had the resuscitation of the child begun. I did not clamp or cut the cord until it had ceased to pulsate. While time is always valuable, the life of the child was considered and given every chance possible.

In the delivery of the placenta, I placed my hand over the fundus of the uterus, and used the Crede's method, "as I do when delivering in normal labor." The separation of the placenta was beautiful to watch. It began at the margins, and little by little, it was separated, and in a few minutes the placenta was placed over to one side, and cut, and tied by the doctor who was resuscitating the child.

Before closing the uterus, I delivered into the vagina a part of my packing which I had decided to use in the uterus, in order to give it something to contract down upon. The packing I used was a three-inch strip of gauze, which had been boiled for a half hour. I began by closing, like to like, from the bottom out, and finished with a Cushing's right angle suture on the uterine incision. The suture material used was No. 2 iodinated catgut.

The abdominal wall was closed by interrupted silkworm gut, in the form of No. 8 figures and silver wire sutures. A drain was left in the lower part of the abdominal incision.

The after treatment was strychnin, morphine, eserin, Fowler-Murphy treatment, and liquid diet for several days. This was practically all that was done for the patient. Only once did the temperature run high, and that was only to 102° on the third day, when there was some evidence of milk in the breast. The nurse placed the babe to breast, and in an hour the temperature was down to 99°.

This operation, coming as an emergency—nothing was in order, and it was in one of our humble homes in which they cook and eat in the same room. The cook table was cleaned up the best

that was possible, but it was not long enough; so by placing an ironing-board on the table, it served as an operating table of proper length. The dining table, about seven feet long, had not been cleaned up since the morning meal, and I had the soiled dishes piled up at one end, as I did not have time and help for shining up the room, as is done in our good hospitals. Desiring to use every care to avoid infection, I boiled towels, pans, instruments and everything used in the operation in one large dishpan for twenty minutes. The abdomen was washed, shaved and painted with an iodine solution, and in about six minutes I had the child out and was waiting on the placenta, as it was separating. In this work I only had the assistance of a physician—Dr. E. C. Freeman, to give the anesthetic, and the help of an excellent nurse to assist in the operation. The time consumed in operation was about twenty-nine minutes.

Mr. President, when I received through Dr. C. A. Abernathy, our excellent secretary of the Tennessee Medical Board of Examiners, your request for this paper, I hesitated for a time as to whether I would undertake to write up the case. But having learned from Escupilapius, our father-preceptor, that we should ever be as ready to help our brother physicians, as to relieve the sick and suffering, I offer this paper with some misgivings as to the medico-legal complication that may follow.

I hope that you and the society which you have the honor to preside over may find something of value in the case here presented. While I would have preferred to have sat at the feet of many and to have been taught by those who have attained to distinction through years of successful practice, yet at your invitation I contribute my humble offering for your entertainment.

N. A. R. D. NOTES—THE USE OF ETHICAL PREPARATIONS.

The official preparations of the United States Pharmacopoeia and the National Formulary are deserving of careful and conscientious study by the physician. With an aggregate of some

fifteen hundred such preparations to select from, they should, in reality, constitute the modern medical man's armamentarium in his fight against sickness and disease.

The more these medical agents are used and studied, the better they are liked, for the very simple reason that they are real therapeutic agents, with a definite pharmacological action, and, if properly employed, will always perform a definite service and one to be depended on. In this manner each one becomes a powerful and true weapon upon which the physician can place dependence.

Such service can not be given by any preparation of unknown composition, because, as every physician knows, *if you do not know exactly what a thing is, you can not state definitely what it will do*. It may be inert for the purpose, or it may be extremely mischievous and detrimental. It is like a child playing with fire.

There is a decided stimulus in things medicinal at the present time, hence we are anxious to awaken a more widespread recognition of the basic principles of this rational materia medica, as represented by the medicaments of the United States Pharmacopœia and National Formulary. By studying the composition, dosage and pharmacological action of these preparations, the medical profession, as represented by the individual practitioner, can rid itself of much of the over confidence in complex mixtures, specialties and nostrums.

Any capable pharmacist can make these preparations, for a trained and expert operator considers it both his duty to make them, and also, his privilege. He is trained to do this work, just as a physician is trained to locate, diagnose and cure disease and sickness.

TWO EXCELLENT REMEDIES.

The following two preparations are most excellent ones from a therapeutic viewpoint, and a thorough familiarity with them will undoubtedly lead the prescriber to employ them as a first choice in the pharmacological conditions indicated:

ELIXIR SODII SALICYLATIS, N. F.

Composition—The Elixir of Sodium Salicylate contains 5 gr. (0.34 gm.) of pure Sodium Salicylate in each fluidram (1 cc.),

in a vehicle of Aromatic Elixir. It is always prepared fresh by the pharmacist when required for use.

Dose.—The average dose of this Elixir is 7 fluidram (4 cc.), after meals, and well diluted. A much larger dose than 5 grains of this salt is often to be administered, sometimes as high as 30 grains. This is readily accomplished by prescribing (in the case of 30-grain doses), 240 grains of the Salicylate to each fluidram of the mixture.

Therapeutics.—The chief use of this preparation is in acute rheumatism, acting as an anodyne and antipyretic; it also lessens the liability to cardiac complications and shortens the duration of the attack. It is a powerful diaphoretic and an efficient cholagogue.

Remarks.—Tablets of Sodium Salicylate should receive little favor from the physician, as their action is generally very irritant, unless accompanied by large draughts of water. They are frequently so hard as to resist all action in the secretions of the stomach and intestines.

According to Moule Sodium Salicylate is a specific in acute rheumatism, but it must be used in larger doses at first than those commonly employed; in severe cases, 30 grains every hour.

Sodium Salicylate is incompatible with mineral acids or with any preparation containing such.

THYMOLIS IODIDUM, U. S. P.

Thymol Iodide is a bright chocolate-colored, or reddish-yellow, bulky powder, with a very slight aromatic odor. It contains 45 per cent of Iodine. It is insoluble in water and glycerin, but readily soluble in fixed oils. It was formerly trade-marked as "Aristol."

Thymol Iodide is a valuable antiseptic, similar to Iodoform. It has the advantage, however, of being less toxic and practically odorless. It may be used as a dusting powder, in ointment or in a solution of Liquid Petrolatum of about 10 per cent strength.

This chemical possesses, in a mild degree, the antiseptic properties of its component ingredients, Thymol and Iodine. Its action is, as a rule, mild, and its greatest activity is made apparent

in nasal and aural affections requiring mild antiseptics. It also favorably influences the course of many cutaneous affections, wounds and sores.

The principal action of this chemical, however, does not reside in its antiseptic properties, but more especially in its direct effect upon the tissues in granulating surfaces. Pharmacologists have not definitely established its peculiarly beneficial action, but it appears to diminish the secretion of the wounded surface and in this manner affords a less suitable medium for the growth of any germs that may be present.

Proceedings of Societies

CINCINNATI ACADEMY OF MEDICINE.

Meeting of April 8, 1912.

Dr. M. L. Heidingsfeld presented a rare type of skin affection, "cutis atrophica idiopathica." Etiology and treatment are not understood; disease of slow progress and benign in character.

The first regular paper was read by Dr. Harry H. Hines, on "Brain Abscess Following Otitis Media—Operation—Recovery," with presentation of the patient. The case showed the difficulty of diagnosis and the effectiveness of the institution of proper surgical treatment. Dr. Hines is to be congratulated on the result in this case.

The second paper, by Dr. W. D. Hines, on "Surgical Lesions of the Stomach and Duodenum," was then read. Dr. Haines dealt at length with the problem of diagnosis and differential diagnosis, and brought out with emphasis that we may at any time have a compound pathology, or one affecting more than one organ in this region, namely, stomach, duodenum, gall-bladder and pancreas, one or all.

The surgical treatment of gastric ulcer is frequently more permanently curative when the gall-bladder is drained at the same time. Pylorectomy is a justifiable procedure in many cases of old chronic ulcer in patients at or past forty years of age. Resection of a solitary ulcer with posterior drainage is better than drainage alone, except where time is an important element. Exploratory surgery is absolutely justifiable in cases not responding to careful medical supervision. Surgery alone can relieve cancer, and should always be resorted to in all forms of pyloric obstruction. Exploration should be early in cancer age cases that show any suspicion of the disease.

Dr. Souther, in discussion, called attention to the practical impossibility of making a differential diagnosis in upper abdominal

conditions, owing to the fact that a circle four inches in diameter would cover all the pathology of the stomach, duodenum, gall-bladder and pancreas. That in the absence of symptoms specially directed to a single condition or organ the diagnostician is left at sea. Frequently, even after the abdomen is opened, there is difficulty in finding the pathology. Pyloric obstruction means operation. Pylorectomy or partial gastrectomy is more curative than gastroenterostomy, and cited personal experience to justify the grounds.

Dr. E. O. Smith then read his paper on "The Complement Fixation Test in the Cure of Gonorrhea." The essayist held that the test is analogous to the Wassermann test in syphilis, the antigen being obtained from twelve types of gonococcus and is polyvalent in character. The test properly carried out is valuable in obscure cases and late as well as latent or systemic gonorrhea. It is valuable in advice as to matrimony, etc.

In the discussion, Dr. Heidingsfeld said his position was very much that of Dr. Smith, but that he had been unfortunate in getting a bad antigen, and had not had the high percentage of positive reactions quoted by Dr. Smith.

Dr. Berghausen gave a scholarly resume of the present status of the work, and added his personal experience. He held that the test has actual merit when in the hands of an experienced man.

Dr. Nelson said the established procedure had given satisfaction in his and others' hands. A positive reaction is valuable, while a negative reaction carries less weight. The test has been of value only since 1911, and then only in the hands of the expert laboratory man. Much more work will have to be done to put this test on a par with the Wassermann in syphilis as a diagnostic measure.

Dr. S. G. Zinke felt that it had a distinct place as a diagnostic measure in differentiating gonorrhea from other similar forms of urethritis and systemic infection.

Dr. Smith in closing called attention to the fact that its use was only indicated where the diagnosis was not possible by the ordinary means, and as a corroborative test of assurance where matrimony was contemplated.

Dr. James H. Williams presented a rare eye case—cystic degeneration of the conjunctiva—with large cyst at the inner canthus and numerous glands of Krause undergoing cystic degeneration.

Dr. Louis Heyn presented a patient with simple pneumothorax, associated with mitral lesion, and gave varieties, diagnosis and treatment instituted in such cases. Dr. Sidney Lange showed a number of X-ray plates, taken of Dr. Heyn's patient, showing needle in place in process of aspirating the air from pleural cavity.

The first regular paper was then read by Dr. Elizabeth Campbell, on "The Feeding of Children from the Bottle to Puberty." Dr. Campbell discussed in a masterly way many very important elements to be considered in the proper development of the child, its appetite and desires for the most valuable food. She reviewed the work that had been done along the line of quantities of the different foods necessary to give proper nourishment to the child of certain weight, and especially emphasized the importance of vegetables as an element of food. She took the ground with Dr. Irving Fisher, that, in order to have proper assimilation or digestion, a desire or hunger for the good was the important thing. She emphasized the importance of developing an appetite or desire for only the kind of food that was best for the child, and the advantage to be gained by never allowing the child to have at any time or to become acquainted with the taste for any form of undesirable food. She took the ground that this element in feeding was prophylactic in character, and very valuable and important in practice.

There was on display on the several tables meals prepared in a scientific way, containing food of sufficient caloric value to nourish a child of different ages for one day.

Mrs. Gilchrist Strong gave a talk from lantern slides, showing the relative food value of different meats and vegetables that form our ordinary foods. Mrs. Strong gave a clear demonstration of the way in which this branch is being taught at the University, and incidentally gave some valuable information in a

commendable way. Her colored slides were from charts made by the United States Government and other standard authorities on caloric value of foodstuffs, and also the relative fat, protein and carbohydrate value.

Dr. Alfred Friedlander, in discussion, commented on the German, American and French methods of teaching this branch of medicine. He felt that the Academy was under obligations to Dr. Campbell and Mrs. Strong for their very excellent presentation of the subject. Dr. E. W. Mitchell also complimented the essayist of the evening, and said he thought it was time well spent on a very important subject.

Dr. H. K. Dunham then read his paper on "Diagnosis of Pulmonary Tuberculosis, Aided by X-ray Stereoscopic Plates." Dr. Dunham's work along this line stands out as a distinct step forward in this field, and ranks very high. A large number of plates were presented to show the value of the method, and, while as a whole it was not original, it represented a compilation of techniques thought to be best. The work has a definite value from a diagnostic standpoint. Dr. Dunham always checks up the plates with the clinical findings. Especial stress is laid on very light percussion and auscultation.

Dr. Moses Scholtz reported a case of an adult male laborer in whom he found a large piece of bone in the rectum, evidently taken in with his food. It was successfully removed.

Dr. Mark A. Brown reported a case of syphilis with a typical blood picture of pernicious anemia. First count showed 1,102,000 reds, and hemoglobin 30 per cent. Patient was in extreme condition, very weak, cachectic and bedridden. He was given seven injections of cacodylate of iron, half a grain each, and then given 0.3 of salvarsan intravenously. In two weeks after admission blood count shows 2,340,000 reds, and 57 per cent hemoglobin. Patient received second dose salvarsan on April 22, and is still improving.

Dr. Ed Wagner presented some patients to demonstrate the luetin reaction in certain cases of syphilis.

Dr. J. Louis Ransohoff reported in detail a case of unilateral septic infarct of the kidney; operation, drainage, recovery. Dr. Ransohoff gave method of diagnosis, which included urinalysis, cystoscopy, color test, physical examination and pain localization symptoms. Kidney was exposed and operated by Cullen wire method and drained. Several infarcts were found in the kidney as well as pus. Patient made a good recovery.

Dr. Jesse Wyler reported a case with symptoms of epilepsy entirely relieved by refraction and wearing suitable glasses. Dr. Wyler did not believe it to be true epilepsy, but reported the case for what it was worth. Dr. Dandman discussed the case, and said he was glad that such important features of refraction had been brought to the attention of the profession, and cited cases in his practice to bear out the value of proper refraction.

Dr. W. D. Haines reported a case of malignant disease of the testicle. He laid stress upon a number of points to be considered in the differential diagnosis. The finding of sero-sanguinous fluid in the tunica vaginalis is always suspicious of malignancy. Among solid tumors of the testicle, tuberculosis, syphilis and cancer are the most common, and solid benign tumors are rare.

Dr. Charles T. Souther reported a case of multiple cystic degeneration of the great omentum and gastro-colic mesentery involving the transverse colon; resection, recovery. In this case the entire omentum, twelve inches of the transverse colon and the gastro-colic mesentery was removed with the cysts, the mass weighing about six to eight pounds. End-to-end anastomosis of the colon was made. Patient had a smooth convalescence and a clean wound, no drainage being used. One cyst was found in the parietal peritoneum, metastatic in character, and patient will be relieved but not cured. Discussed by Dr. J. A. Johnston, who called attention to the difficulty in making the diagnosis in these

cases, and the necessity of being able to deal with any condition found when the abdomen was opened.

The Academy had the following distinguished visitors present, who made short speeches at the invitation of the President: Dr. O. G. Pfaff, of Indianapolis; Dr. Brayton, of Indianapolis; Dr. A. B. Davis, of New York City; Prof. Charles Richmond Henderson, of Chicago.

Dr. Davis gave a very interesting talk on Cæsarean section, of which he has done one hundred and thirty-four operations. He outlined the indications and described his technique.

Prof. Henderson gave a very eloquent address on special economics. He plead for the full coöperation of the medical profession with workers in sociology, looking toward the enactment of legislation to better man's economic relations.

The Academy then adjourned to enjoy liquid refreshments and cigars.

Dr. W. D. Hines made a motion to have Wassermann reactions made by the Health Department, free of charge, in cases of indigent afflicted. This service to be open to any physician's charity patients, and that the secretary be instructed to notify the Health Department of said action. Dr. Haines suggested further that all requests for test be accompanied by certificates stating that the case in question is really deserving of charity. Carried.

Dr. C. R. Holmes presented a series of twelve mastoid cases that had been operated by the modern blood clot method, and reviewed in detail the relative merits of the old and new methods. He held that the patients recover very much earlier, and the ultimate results as to hearing are much better than formerly. The method is ideal for chronic cases. Primary union can be expected even though a typically radical operation is done. The blood clot may show signs of softening and breaking down, but no effort is made to drain. Special effort is made to preserve the periosteum and to carefully stitch it back in place to cover all of the denuded bone area. Great care is exercised to remove all

diseased tissue. The wound is then sterilized, first by full strength peroxide of hydrogen for three minutes, followed with alcohol 98 per cent for three minutes, then closed by suturing the periosteum with catgut and the skin and muscular separately with silkworm gut. Acute cases are less favorable for this method on account of the higher degree of virulence of the infecting microorganisms, but it is still the most desirable. The technique for acute cases is the same as for chronic cases. In acute cases the wounds frequently become very foul on the fifth to the tenth day, but nothing is done except to change the dressing and mop them clean and in a few days they clear up. Progress is very much more rapid than by the older methods. The patients are saved the pain and long-continued after-dressing formerly required. The method marks a most distinct advance in treating this type of cases.

Dr. E. M. Baehr presented a patient, male, forty-seven, tanner by trade, suffering from muscular atrophy due to paralysis of the suprascapular nerve. The modified use of arm was demonstrated with corresponding infrascapular muscular atrophy.

Dr. W. D. Haines presented a patient with a rupture of the short head of the biceps of the left arm, at the musculo-tendinous portion. It is the third case he has seen. He presented the other two cases to the Academy. No special treatment was advised, as the patient's general musculature and condition did not warrant an anesthetic. Prognosis was very much reduced function for the arm in the future.

Dr. Porter called attention to the delinquent members and the effect it had on the number of delegates to the State meeting. Dr. C. L. Bonifield then made a motion that a committee of three be appointed to arrange for the Academy to have a full representation of delegates at the State society, seconded by Dr. Haines and carried. The president then appointed on that committee Drs. Bonifield, Holmes and Mitchell. Dr. A. G. Drury (treasurer) stated that the probable deficiency would not be great, provided the members responded as well as he expected this week.

The regular paper of the evening was then read by Dr. C. R. Holmes on "Development and Construction of Tuberculosis Sanatoria in Europe and America." Dr. Holmes showed a large number of lantern slides to illustrate the different types of buildings in different countries. He gave Germany first place in their efforts and ability to care for their tubercular cases, and Denmark second. New York City ranks first in this country. The general conclusions were to the effect that the group or colony type of small buildings were the most satisfactory. That the inexpensive cottage was the best. That buildings to accommodate from five to twenty patients was probably the most desirable type. The paper contained a great deal of general interest in hospital construction and represents the expenditure of a great deal of time, money and personal effort on the part of Dr. Holmes to get the most modern ideas on what is best for Cincinnati in hospital construction. The paper will appear in full in *The Lancet-Clinic* at a future time.

The Academy extended a vote of thanks to Dr. Holmes for his most valuable paper.

Selected Articles

THE SIGNIFICANCE OF PAIN IN ABDOMINAL DIAGNOSIS.

I.

FROM THE SURGICAL STANDPOINT.

BY JAMES P. WARBASSE, M.D., of Brooklyn, N. Y.

The consideration of abdominal pain from a surgical standpoint demands, first, that an examination shall be made. One of the weaknesses of general practice is the disposition on the part of the practitioner to prescribe for abdominal pains without exposing the abdomen and palpating the naked body. I, personally, am constantly hearing of the horrible results of this neglect, and so, while none of you may be aware of such neglect, I assure you that I have it upon good authority that it does exist.

It is quite essential to differentiate between the voluntary rigidity of the abdominal muscles and the involuntary or protective rigidity. That is something which I shall not take the time to discuss. To make this differentiation comes only from practice, but we are constantly seeing men of inexperience failing to differentiate between a voluntary rigidity (which a patient purposely maintains, either to deceive the examiner or because he is fearful of being hurt) and involuntary rigidity which can not be controlled and which is entirely protective. I shall speak chiefly of colic.

As a matter of fact, colic embraces most of the abdominal pains. Colic is a disease of the peritoneum. I do not know that it is generally described in that sense, but if you will recall the condition in which colic occurs, you will see that it takes place in hollow viscera which are covered by peritoneum. Indeed we have no colic of the tubes outside of the region of the peritoneum. In the upper gall tract, stones lodged in the hepatic ducts and surrounded by liver and connective tissue do not give rise to colic, but when the stones come down and engage in the common duct or the cystic duct, this symptom, which we call gall-stone colic,

develops. Colic in the uterus, colic in the kidney, I conceive as being a peritoneal manifestation. When a stone passing through the ureter has passed the peritoneal region, the colic which characterizes its passage through the peritoneum-covered ureter ceases. Over-distension of the bladder gives rise to a pain which is comparable in every sense to a distension of any of these peritoneum-covered viscera, such as the intestinal colic with which we are familiar. Colic is a pain due to the distension of a viscus covered by peritoneum. It is possible that some of the physiologists present or medical internists may dispute this proposition.

Gastric ulcer I will discuss as the first surgical pain-producing condition. The pain may not necessarily be the prominent symptom. Usually it is referred to the epigastrium, whence it may radiate in various directions, generally toward the left subscapular region. The right subscapular region may be the seat of the reflex pain if the ulcer is at the extreme right side of the stomach. This pain is increased upon taking food. The pain does not come on immediately after the ingestion of food, but usually about one-half hour; and it seems from a collection of autopsy findings in these cases, that the further away from the cardia the ulcer is located, the later the pain, so that if the ulcer is located near the pyloric end of the stomach, the pain may not begin for two or three hours after the ingestion of food. Epigastric tenderness is usually well marked, and often with rigidity of the recti muscles. This tenderness is definitely localized, as well as the pain, and may be given as characteristic of gastric ulcer.

Vomiting gives relief to this pain. Spasm of the pylorus with its concomitant symptoms may be induced by the presence of the ulcer and give the peculiar pain of spasm of the pylorus. The typical pain develops gradually. It is a burning or boring pain, and often radiates to the back or up into the precordium. It is regular in its occurrence and may be expected usually to come on with a fixed regularity after the ingestion of food. The patients speak of the pain pretty definitely as coming on with fairly certain regularity after eating. The tenderness is pronounced. It is sharply localized in a small area. Diffuse pain usually speaks against ulcer. Exceptionally it may be an aching or dull pain. It may occur only after some particular articles of diet which a patient finds

disagree with him or after some dietary indiscretion.

Pain which is constant or is present before breakfast is rarely due to gastric ulcer. Pain beginning immediately upon taking food is also rarely due to gastric ulcer. In old ulcers the pain may be absent. A practical contribution to the subject will be found in a paper by Dudley Roberts, published in the *Medical Record* of the 17th of October, 1908.

Pain due to cancer of the stomach is variable in its character. It may be absent. There may be only a sense of discomfort after eating which can not be characterized as pain. It is calculated by collecting large series of cases that pain is present in about 85 to 90 per cent of the cases of gastric carcinoma. About one-half of the cases suffer severe pain. It may be continuous with exacerbations after eating, or it may be present only after eating. In some cases it appears only after the ingestion of solids. In pyloric cancer, that is, the cancer which is producing some obstruction to the emptying of the stomach, peristalsis causes the pain of obstruction which is relieved by vomiting. Usually this pain is referred to the epigastric region, occasionally passing through to the back, or in some cases felt only in the back. Absence of tenderness, as you are aware, in cancer of the stomach, is the feature which is generally counted upon to differentiate it from gastric ulcer. Carcinoma of the stomach (the few cases which have been studied) give the symptom of pain quite similar to the pain of cancer of the stomach.

In ulcer of the duodenum, the pain may not occur until three or four or even more hours after the ingestion of food, which means that the pain is felt when the food is poured through the pylorus and enters the duodenum. Because of the slower digestion in the night, a patient who has taken a meal late in the day, may not suffer the pain of ulcer of the duodenum until more than four hours; six to eight hours may elapse. These patients are awakened in the night with the peculiar pain. It seems that the pain may be relieved by again taking light food, which apparently acts as a counter-irritant, as it were, causing a physiologic congestion of the stomach and a relief of the duodenal pain.

The pain due to pancreatic disease has been much studied recently. I would refer you for an admirable discussion of this

subject, to a paper by Dr. H. G. Webster on the pathology and diagnosis of pancreatitis, published in the *New York State Journal of Medicine* (September, 1908), which contains a clear description of the pain of pancreatitis. These cases present a dull pain which occupies the middle of the abdomen (the umbilical and epigastric regions). It may radiate but is usually confined, and in the cases in which there is an acute pancreatitis the pain is constant. A healthy adult suddenly seized with a mid-abdominal pain, should prompt us to suspect acute pancreatitis, and the associated characteristic symptoms may be depended upon to clear up the diagnosis. Jaundice in pancreatic disease with this dull pain is often present and differentiates itself from the jaundice of a biliary disease (common duct obstruction) by the absence of the colic. The head of the pancreas presses the outlet of the common duct and produces a backing up of the bile without the obstructive colic.

In the bile tract, the pains which are encountered are rather characteristic. A valuable diagnostic expedient in this region is to hook the fingers up under the arch of the ribs and it will be observed, if the pain is due to obstructive or inflammatory disease of the bile tract, that the patient will not be able to take a full inspiration. In appendicitis, for example, if that test is tried, the patient will be able to take an inspiration; or, if the pain is due to gastric ulcer, the patient will inspire deeply. In cholelithiasis, the pain is usually not relieved by vomiting, which differentiates that on the other hand from pain of gastric ulcer which is commonly relieved by vomiting. Tenderness over the gall bladder usually indicates inflammation of that organ, but we should bear in mind that tenderness in that region may be due to hydronephrosis, to an inflammatory condition about the pylorus, or to ulcer of the duodenum. No intervals between the attacks of pain point to cholelithiasis. Pain is not usually present in malignant disease of the bile tract or at least is very slight.

In typhoid ulcer the pain usually begins when the ulcer perforates, but there is tenderness so soon as the peritoneum becomes involved. Palpation of the typhoid abdomen will elicit pain when typhoid ulcers are producing an infiltration of the peritoneum. Of course, these ulcers may not perforate, but it is commonly

after such tenderness that perforation takes place; and we find in the histories of cases which have been palpated for pain, that there was usually pain (a distinct evidence of peritoneal infiltration) before the sudden and characteristic pain of perforation of the ulcer occurred.

Of the pain of appendicitis, I shall speak but briefly. As you are aware, it is referred at first to the umbilical region and is associated with the vomiting. It is a colicky pain which gradually migrates the region of the appendix. In chronic appendicitis, the pain may be confusing. Indeed, there may be no pain at all. It may be simply a dull aching or only present when the cecum is distended. The painful sensations and discomforts which are found in chronic appendicitis cover a large range. A sign of some interest, I think, in this connection, is the fact that pain, associated with appendicitis, is usually not directly at McBurney's point. Anatomically the base of the appendix is usually at McBurney's point. If we carefully palpate the region of the pain, we find the most exquisitely tender spot somewhere in the neighborhood of McBurney's point, and if we make a dot on each of these two points, McBurney's point representing the base of the appendix, and the other the point of greatest tenderness, and connect them by a line, that line will represent pretty generally the direction of the appendix. This is commonly a valuable thing to know before we open the abdomen.

The differentiation of the pain of appendicitis from other pains, I may speak of briefly. In tuberculosis of the cecum the pain is a more constant pain without the colicky feature of the appendicitis. In cancer of the cecum there is apt to be a pain which is colicky in the beginning, representing the symptoms of a moderate degree of obstruction. The intestinal muscularis becoming hypertrophied, forces the intestinal contents through the narrowed lumen, giving rise to colicky pains. Later, there comes a time when the pain becomes that characteristic of acute intestinal obstruction. The pain of ureteral colic must also be differentiated.

The pain of rheumatoid arthritis of the vertebral joints affects the nerves leaving the vertebræ. This condition may produce a hyper-sensitiveness of the abdominal wall which has not infrequently been confused with appendicitis. In all of these

reflex pains, however, the rigidity, which is partly a voluntary rigidity, yields to continuous pressure. It is not spastic like that which characterizes the involuntary protective rigidity. The pain of *tabes dorsalis* with abdominal crises must also be differentiated.

In herpes zoster of the 11th and 12th dorsal nerves and the 1st and 2nd lumbar nerves, there is a sharp boring pain with an exquisite sensitiveness of the abdominal wall, which must be differentiated from that of a lesion in an underlying organ; but here again continuous pressure causes the rigidity to yield. It has happened that the vesicles which appear in herpes zoster have been mistaken on the third or fourth day for vesicles due to applications to relieve pain.

In perityphlitis the pain is more of a steady discomfort without the colicky features unless an appendicitis is superadded. Appendicular colic produces a pain quite characteristic without the distinct muscular protective rigidity. The rigidity, however, supervenes when infiltration of the appendix or an inflammation or infective condition develops. Intestinal colic, acute enteritis, right pneumonia, abscess of the right ovary, all produce right sided pain which must be differentiated from that of appendicitis.

In acute intestinal obstruction, the pain is a distinctly colicky pain. Here we have a distended viscus with its muscularis attempting to overcome an obstruction. This pain persists so long as the muscularis is attempting to overcome the obstructing condition. When sufficient absorption of toxins has taken place to paralyze the muscularis and to anesthetize to a degree the nerves of the bowel, the pain subsides, even though the bowel be greatly distended. Pain arising from the female generative organs I shall not take time to speak of.

The most striking pain from the urinary organs is that of ureteral calculus, which is violent with reflex pain in the groin, scrotum or labia, and the colicky reflexes which tend to cause vomiting. This pain continues to be excruciating so long as the stone is engaged in the part of the ureter covered by peritoneum. The pain suddenly stops when the stone returns to the pelvis of the kidney or enters the bladder. There is a pain, similar to that arising from urinary obstruction, due to angulation of the ureters; also a pain peculiar to movable kidney in which not only the ure-

ter may become angulated and the passage of urine checked, but in which there is actually an angulation of the blood vessels as well, giving rise to a sudden excruciating pain radiating to the groin and as suddenly subsiding when the angulation is relieved by position or manipulation.

The pain of peritonitis, with which I shall close, is colicky for the reason that peritonitis does not give rise to any considerable pain unless it interferes with the function of some viscus covered by peritoneum. The pain which we observe in peritonitis is the pain which supervenes when the intestine has become paralyzed by infiltration of the muscularis with inflammatory products. Ordinarily, peritonitis itself, gives little or no pain. There is tenderness, to be sure, but the pain of peritonitis is secondary pain which is entirely comparable to the pain of intestinal obstruction. In peritonitis, a certain part of the bowel may become paralyzed, and that part of the bowel acts precisely as a segment of bowel which is the seat of some obstructed condition. Indeed, the symptoms are the same. The bowel is paralyzed; it no longer propels along its contents. Material from above forced into this segment does not pass along. Peristalsis is paralyzed, and the pain in these cases is in the segment of intestine immediately above the bowel which is the seat of paralysis.

II.

FROM THE MEDICAL STANDPOINT.

BY FRANK BETHEL CROSS, M.D., of Brooklyn, N. Y.

The question that arises in our minds is, just *how much dependence in diagnosis can we place upon the one symptom of pain?* Exceptional diagnosis, brilliant diagnoses are made upon the pain alone. Those of us who were fortunate enough to receive instruction from Dr. Starr, recall his recital of the celebrated case of Dr. Charcot: the boy who was brought to Dr. Charcot in evident ill health, from whom no history was obtained, except that he knew that some time in the night he was awakened by pain in the left thumb. The diagnosis was nocturnal epilepsy, with a distinct aura.

We know that in cases presenting classical pain a definite diagnosis can almost be made upon the pain alone, but it is not the cases presenting classical pain that give trouble; it is the large number of cases presenting atypical pain, like those presenting atypical histories, that are the cases difficult of diagnosis, and without proper diagnosis our treatment is apt to be in error.

It would seem as though abdominal pain could only be depended upon in diagnosis when it can be substantiated, and it is interesting to note that the essayists this evening present that suggestion. That would be necessary because of the great variety of atypical forms of pain.

Pain is suggestive in its location, its mode of onset, its character, severity, duration and tendency to recur. When we are helped out by a case history (an accurate one), palpation, and possibly X-ray examination, a diagnosis under these circumstances becomes probable. As additional aids in diagnosis, we have accompanying symptoms of nausea, vomiting, hematemesis, vertigo, syncope, hematuria and rectal discharges. These all help us greatly. It would seem as though the wisest thing to do, barring that the pain is of "acute surgical disease of the right half of the abdomen," would be to observe the case and make the diagnosis while the case is under observation and treatment, treatment under these circumstances being limited to relief of pain. There seems to be nothing like clinical observation of the case. We base our diagnosis upon observation of the case from day to day and not upon the mere presence of pain or upon the one examination.

As a general thing, it may be said that pains correspond in their location to the organ in which the disease process actually is but we can not lay down any definite law. This is a general principle. There are many exceptions. Local causes may produce general abdominal pain, as evidenced in appendicitis with which we are so familiar. On the other hand, a general abdominal condition can produce local pain. How many times in a case of typhoid does our patient complain of localized abdominal pain?

The most severe abdominal pains are usually due to some grave condition, generally of surgical importance, and I can not lay too much stress upon the advisability under these circumstances of

always having surgical advice. It seems to me that many of the errors that are laid at the doors of medical men could be avoided by having surgical opinion. In the hospitals it is easy to obtain this, and we should certainly in our private practice not deprive ourselves of the aid that we seek in our hospital services.

There has been very little mention to-night of perhaps the most frequent cause of abdominal pain, though it has been referred to indirectly; that is, the condition of constipation, an every-day complaint generally attended with considerable discomfort.

Regarding Dr. Warbasse's theory of peritoneal irritation in abdominal pain characterized by colic, it would seem almost as though he had answered his own proposition when he explained the pathology of intestinal colic, as a tension placed upon the fibres of the muscularis muscosa.

Dr. Cabot, in his recent book on differential diagnosis, which is fresh from the press, lays down briefly general principles to obtain in the consideration of abdominal pain. He says that under ordinary circumstances in the great majority of cases, general abdominal pain will be found to be due to gastro-intestinal conditions. If our patients are women, we must take into consideration at once the possibility of some disturbance in the internal genitalia. In middle life there is a particular predilection to gall bladder disease. If our patients are old men or young girls, summarizing everything, he says that we should always consider the urinary tract. This provides us with a brief working basis.—*Long Island Medical Journal.*

Extracts from Home and Foreign Journals.

SURGICAL

NEPHROPEXY.

The author states that surgical intervention for nephroptosis is based upon the principle that the kidney is not an abdominal organ but that it is outside of the abdominal cavity.

Many cases of loose kidney are due to a fall or a strain, especially in young women. Sometimes it seems due to severe labor. The kidney is the only loose organ, all others seem to be in place. In the early stages of the condition, comparatively few symptoms are produced; they gradually increase in severity, giving rise to disturbances of digestion, flatulency, atony of the colon, etc., and as the kidney becomes looser, twisting occurs, and nephritic colic develops.

The nervous symptoms are the principal signs, besides those mentioned, and these are so diverse and numerous that simply by being on the lookout you will find them. A great many are of a hysterical nature and some are found in neurasthenia. Then we have actual pains, and reflex headaches and even insanities of various kinds, and here comes in the fine diagnostician.

The other class of cases where there is a general relaxed condition of the abdominal organs, and also of the kidney, have similar symptoms, aggravated if anything. Placing such a patient on the back, the loose kidney is easily found, but the condition of the abdominal viscera is overlooked; fixation of the kidney is made and the patient not cured.

In case of general abdominal ptosis, the kidney should be fixed first and then the other treatment instituted to cure the patient.

Fixation by the fibrous capsule is permanent. An incision is made at the convex border, from one pole to another, the capsule stripped off on one side and torn towards the pelvis of the kidney. The same procedure is then carried out on the other end of the kidney. The resulting incision is like the letter "Z." The

upper flap is sutured to the erector spina muscle. The lower flap is sutured to the quadratus lumborum at the lower angle of the wound.

The author concludes that:

1. The kidney is not an abdominal organ.
2. The movable kidney produces in many cases great distress and the most diverse symptoms.—*The Post-Graduate*.

A NEPHRECTOMY ON A WOMAN SIX MONTHS PREGNANT, NO INTERFERENCE WITH PREGNANCY.

Mrs. W. H. H., a white woman, age 22, was admitted to Ward 50, October 27, 1911, with a temperature of 104°, showing all the signs of some thorough intoxication. She was very much depressed and stupid, and unable to give a connected history. The blood was examined, but showed nothing of any importance. No Widal reaction or plasmodium; she looked so typical of typhoid, however, that she was treated for that trouble. On examination it was found that she was about six months pregnant. The urine showed pus, casts and albumin.

On October 30 she showed some signs of abortion and was moved to ward 48. There she was carefully watched and treated systematically. The pains and hemorrhage left her, but she still remained profusely septic and looked as though she could stand a very little more. As she complained of pain on right side, the ureters were catheterized and the urine from the right side showed pus flowing and then clear urine with another spurt of pus, followed again by urine, this to continue as long as the catheter remains in situ. On the left side the urine was normal. As she continued to grow worse it was decided to expose the right kidney and see if something could not be done to help her. She was prepared, brought to the amphitheater, and, under a general anesthetic, the kidney was quickly exposed through the lumbar incision and brought to the surface, where it was found to be studded with small tubercular abscesses, and in such a condition that nothing but total removal seemed justified. This was done quick-

ly and the patient returned to the ward. The temperature dropped to normal and continued there with the patient improving generally, until about the 20th of November, when she had a rise of temperature, and a cystoscopic examination showed pus still coming from the side from which the kidney was removed, due, I suppose, to the fact that the ligature cut through the ureter and the pus flowed through this patulous channel into the bladder. The wound in the back was washed out carefully and a larger drain inserted, and she has improved rapidly since, all pus having disappeared.

It was necessary to give her hypodermoclysis for weeks, and this caused several abscesses, which were incised and drained.

She is up and about now, and has shown no more symptoms of abortion, and looks as though she might, from present indications, carry the full nine months—*New Orleans Med. and Surg. Journal*.

TINCTURE OF IODINE IN SURGERY

Reclus praises most fervently the routine use of tincture of iodine in surgery. He compares the elaborate method of treating a contused or lacerated wound of the hand by scrubbing and washing with various applications, all taking up much time, with the simplicity of the iodine treatment. Compresses wet with tincture of iodine are applied to the wound and the surrounding skin is painted over. The whole proceeding only occupies a few minutes. Fresh dressings are applied daily so long as discharge continues. Then a dressing every third or fifth day is all that is necessary. Crusts or coatings over the wound are washed away with peroxide of hydrogen. The pain involved is not of consequence. Reclus tried the method on himself and found that the burning feeling first produced soon passes away. He has not used iodine for extensive burns, but one of his colleagues has done so most successfully in most extensive lesions. Some skins blister after use of iodine, but Reclus has only observed three cases after using the method for a year in his large hospital experience. Even these cases quickly got over the irritation. The caustic properties of old prepa-

rations have been set down to hydriodic acid. Tincture of iodine is not a stable compound and soon decomposes, hydriodic acid being formed. Another cause is that age increases the strength of the iodine as the spirit evaporates by degrees. It is therefore important to use a freshly made tincture or to add to the preparation, if it is to be kept, iodide of potassium in the proportion of gr. xv. to the ounce. Suppurating wounds do very well under this treatment. Cellulitis seems to be prevented from spreading. Reclus recommends that all crushes of the extremities should thus be treated and reports excellent results in compound fractures. He quotes a case of very extensive spreading gangrene involving the belly walls, thorax, and axillæ, in which recovery followed a thorough application of iodine.—(*La Press Medicale*).—(*The Practitioner*, Nov., 1911).—*Pacific Medical Journal*.

SURGICAL USE OF PICRIC ACID.

Dr. A. Ehrenfreid (*Bulletin Therapeutique*, January 23, 1912), finds that an aqueous solution of picric acid, $\frac{1}{2}$ per cent, destroys in half an hour virulent microbes, and is 50 times stronger in bactericidal action than a 1 per cent solution of phenol. Picric acid was employed in more than 300 cases of burns of the first, second and third degree in children and adults, on recent wounds, and ulcers, with satisfactory results, and in no case were yellow colorations of the integuments or of the urine observed after external application. The best solution for general use is $\frac{1}{2}$ of 1 per cent of picric acid, which can be prepared by dissolving the crystalline picric acid in boiling water. The solution is used by impregnating tampons of gauze with the solution; for the burns of the extremities, immersion of the parts in the solution was employed and then covered with gauze moistened with the solution. For burns of first and second degree and in superficial lesions, the picric acid solution, according to this authority, is superior to all other antiseptic dressings. Extensive burns of the third degree are not amenable to this treatment.—*La Tribune Medicale*.

MALIGNANT DISEASE OF THE TESTICLES.

Mr. H. Morrision Davies (*Lancet*, Feb. 17, 1912), from a study of this subject and his own experience, presents the following summary: 1. All tumors of the testicle must be regarded as malignant. 2. The history of previous venereal disease, the association of the swelling of the testicle with an injury, the length of the history dating perhaps from childhood, must not be allowed to outweigh clinical evidence. 3. Always suspect a tumor of the testicles when there is an oval swelling which is not translucent and comparatively painless. 4. When the tumor is in addition soft or elastic, and the surface shows slight lobulations, regard the suspicions as confirmed. 5. Increased pulsation of the cord is in favor of tumor, but is not pathognomonic. 6. A solid tumor may be so elastic as to give the feel of a fluid swelling. 7. The aberrant clinical manifestations of a testicular neoplasm must be constantly borne in mind. 8. If the diagnosis is uncertain and the possibility of a growth is entertained the tumor must be explored. Should the tumor be syphilitic, no harm will have been done; if tubercular or a hematoma, operation is the correct treatment. 9. When the diagnosis of tumor is confirmed the complete radical operation, consisting of removal of testicle, cord, lymphatics, and surrounding fascia, and of the lymphatic glands in the region of the aorta and vena cava, must be done, unless the lumbar glands are extensively involved, or there are evidences of metastases elsewhere.—*International Journal of Surgery*.

SKIN DISINFECTION AND SURGICAL ASEPSIS.

Dr. Gustavus M. Blech (*St. Louis Medical Review*, March), concludes, in the light of his experience with iodine as a skin disinfectant, that the Grossich method is far from being an ideal one, since it has failed to prevent stitch abscesses in clean appendectomies, extirpation of tumors and goiter. He has had far better results with the use of much green soap and very little hot water, followed by rinsing with alcohol.

The author believes "that there is no golden rod of ease to the goal of asepsis, that no one chemical can aid us to achieve that

result, the general care in preparation and minutiae should not be relaxed for one moment, that it is unscientific, irrational and dangerous to 'destroy' actual dirt on the operative field by mere dry shaving and painting twice in a few minutes with the germ-killer (?) iodine in alcoholic solution."—*The Am. Journal of Clin. Med.*

EPIDIDYMITIS, TREATMENT OF GONORRHEAL.

When a gonorrheal patient complains of tenderness over the point where the cord passes through the external ring, he should be ordered to bed at once and the scrotum supported by a broad strip of adhesive stretched over the anterior surfaces of the thighs. Many an attack of epididymitis may thus be avoided, the vasitis which is the cause of the tenderness mentioned then subsiding.

Epididymitis ensues a day or two after the onset of vasitis. The scrotum should here likewise be supported upon the adhesive plaster bridge. Poultices applied to the scrotum give marked relief, but ice applications are to be avoided, as gangrene may follow their use. The following ointment, to be smeared on a cloth and applied to the scrotum, has given the author good results:

℞ Mentholis, gr. xv (1 Gm.).
 Ung. belladonnæ, gr. xx (1.3 Gm.).
 Ung. Crede, gr. xxx (2 Gm.).
 Ichthyolis, ʒj (4 Gm.).
 Petrolati, q. s. ad ʒj (32 Gm.).—M.

The swelling subsides in about ten days, often leaving an indurated nodule of the size of a pea at the lower or upper pole of the epididymis. Although this nodule does no harm, unless it is so located as to obstruct the orifice of the vas, it is often a source of anxiety to the patient. It may gradually disappear, but in case it persists and the patient desires its removal the scrotum may be opened and a criss-cross incision of the tunica albuginea made over it. This maneuver is almost invariably successful.

If the swelling of the epididymis does not quickly resolve, the testicle should be strapped, as follows: Envelop the affected half of the scrotum in a square of gauze. Encircle the upper pole of the testicle with the thumb and index fingers, pressing the testicle

into the bottom of the scrotum, and bind a strip of adhesive above the organ so tightly that it can not slip through. Starting at this so-called "choker" strips of adhesive around under the testicle to the opposite side of the choker until the entire organ is covered, then apply a second choker over the ends of the strips. When strapped, the size of the testicle rapidly diminishes, necessitating the renewal of the strapping every second day. The strapped testicle should be supported by a suspensory.—C. W. Bethune (*Buffalo Medical Journal*, November, 1911).

APPENDICITIS AS A BORDERLAND DISEASE.

Krogus writes in the interest of harmony between physician and surgeon in respect to the choice of treatment of appendicitis. Himself a surgeon, he appears to find a ready way out of the dilemma without prejudice to either side. There is a benign appendicitis which is regular in course and shows no evidence of unfavorable progress, but instead the tendency is always to betterment. When the symptoms persist without tendency to improve the condition becomes a surgical one; and much more so is this the case where the evidence, however slight it may seem, shows a tendency to aggravation. Even a single symptom, become ever so little worse, indicates early operation. The prognosis is by so much graver, and need of intervention the more urgent when any one symptom becomes greatly aggravated, or when several unfavorable symptoms coexist. If after one attack resolution does not take place within reasonable time, when pain returns and does not abate again, or when a second attack of vomiting or a second chill occurs or when there is only persistent tenderness to pressure without tendency to lessen, it is as good as a diagnosis of impending gangrene or perforation and operation should not be deferred a day. No time should be lost through the palliative use of morphine. If the pain is severe enough for that, the condition is serious enough for operation. The author has now made use of these principles for seven years with a material of hundreds of cases, and in not one has his judgment been misplaced. If the conditions are balanced so evenly that a choice is impossible, one must operate, of course.—*Medical Record*.

MEDICAL

MOUSE TUMORS AND SELENIUM.

That chemo-therapy, as elaborated by Paul Ehrlich, would continue to develop in other fields than in diseases caused by spirochetes has been doubted only by the worst pessimists. The scientific principles underlying the discovery of salvarsan should show the way to find other similar remedies. Following this trail Dr. Wassermann and his co-workers appear to have made a remarkable observation that "mouse tumors" were favorably influenced by a combination of selenium and eosin. This remedy "has a selective action for the cancerous mass," and caused its liquefaction after three injections. Of course, the discovery has not yet reached the stage when it is available as a remedy for cancer, but is now being studied with the view of finding a preparation free from toxic effect yet possessing the virtues of selenium. Many of the mice treated died, but some lived and appeared to be cured. With such able men working to find a suitable chemical combination—free from deleterious effects—we may at least wish them success. Nothing yet has been done which can be utilized in the treatment of cancer. Unfortunately, the lay press has given much space to sensational and unwarranted reports. Soon quacks and vampires will be preying upon the gullible public with fake remedies purporting to be Wassermann's discovery.—*Journal-Record of Medicine*.

THE MUSICAL MEMORY AND ITS DERANGEMENTS (AMUSIA).

J. Leonard Corning, New York, presents a resume of the psychology of the musical memory, describes the localization of this faculty in the vicinity of the speech centers, and reports illustrative cases showing how lesions of the cerebral tracts causing aphasia, alexia, and agraphia may be accompanied by a loss of musical memory in its various aspects. The musical faculty is developed very early, tone images being formed before word images. Memory is not a simple faculty, but there are many differ-

ent kinds of memory, such as sound and other sense memories, word memories, motor memories, sensory memories, etc. The musical memory includes auditory, visual, and motor memories. The sense of time, rhythm, melody, and harmony are equally important. Musical memory, then, is not a simple matter. The player of instrumental music has much more to learn than the vocalist, since the process of memory is here much more complex. Memory varies very greatly in different individuals as to its constituents and action. With some the auditory memory is much better than the motor memory. Some remember the printed notes, others the sounds and harmony. Any pathological condition lessening or disturbing the cerebral, and especially the cortical, nutrition, may cause derangement of memory and attention. Such is the case with the effects of alcohol, tobacco, and other narcotics. Attention is of the greatest importance to the musician. In committing anything to memory excessive fatigue should be avoided, periods of twenty minutes of effort being interspersed with periods of rest. The phenomenon of automatism after practice is of the first importance to the musical memory, the playing of pieces becoming automatic after a time. With the singer an auditory-motor bond need not be established. In the faculty of memory auditory association is the principal factor. There may be a congenital absence of the musical faculty, and states in which apoplexy or paralysis play a part are frequently accompanied by loss of musical memory.—*Medical Record*.

UROTROPIN IN PURULENT MENINGITIS.

James F. McKernon, New York (*Annals of Otology and Laryngology*, December, 1911), discusses "Urotropin in the Treatment of Purulent Meningitis." After withdrawing the cerebro-spinal fluid he introduced 50 grs. of urotropin in from 15 to 20 cc. of normal salt solution. There was a marked drop in the temperature within four hours after the injection. The streptococcus, he says, will not live in the presence of the concentrated solution of urotropin. He has used the method in three cases, and the results were sufficiently encouraging to

make him believe it is of distinct advantage in the treatment of purulent meningitis of otitic origin. In two of the cases there was a complete coma until the urotropin was injected. Several hours after the injection consciousness returned. Whether the improvement was coincident in these cases, or due to the urotropin, he could not say.—*The Lancet-Clinic*.

THE TREATMENT OF PLEURAL EXUDATES.

Drs. Karl and Silvio von Ruck, in their report from the Winyan Sanatorium, Asheville, N. C., for 1911, advocate the use of tincture of green soap in the cases of pleurisy with effusion in which the latter is not absorbed promptly. This treatment has proven valuable in many instances, not only when the exudate was serous or sero-fibrinous and of recent date, but also in all cases of fibroelastic exudates and pleural thickening.

The green soap is applied by friction over the affected side after the skin has been washed with ordinary soap and water. As a rule the application is made at bedtime, is allowed to remain over night, and is repeated daily, or less frequently, depending upon the tolerance of the skin. When hyperemia occurs as an effect of irritation this is allowed to subside before the application is repeated. In many cases the skin is tolerant enough to permit daily applications; in others marked hyperemia follows after its first use, in which event the soap must be diluted.—*The American Journal of Clinical Medicine*.

THE PUPILS IN PHTHISIS.

J. L. Tuechter, Cincinnati (*Journal A. M. A.*) says that a pupillary difference as a symptom in unilateral pulmonary tuberculosis has been recognized for some time and is of some importance, deserving more attention than it has received. It is not always present, but if there is a difference it will be noted that the dilated pupil is sluggish, reacting slowly. From observation of a larger number of cases Tuechter is satisfied that a comparative dilation of one pupil signifies an enlargement of

the bronchial lymph-nodes on the corresponding side, and as such glandular involvement is usually tuberculous and occurs at a time when the lung itself does not show destructive changes, he feels that the sign is most valuable in the early diagnosis of pulmonary phthisis. It is necessary, of course, to rule out ocular conditions, which may cause the difference, and certain conditions of the thorax, such as tumor or aneurysm. Several cases illustrating that the pupillary difference not due to pathologic conditions of the eye is a valuable early sign in phthisis, with or without other symptoms, are reported. As it is due to bronchial gland involvement, it is not necessarily dependent on any condition of the lungs.—*The St. Louis Medical Review*.

SODIUM CACODYLATE IN ERYTHEMA MULTIFORME.

W. Cuthbertson, of Chicago, reports a case of erythema multiforme in a woman aged 27 that had existed from childhood, occurring every fall and disappearing in the winter. Intramuscular injections of three-quarters of a grain of sodium cacodylate, given twice a week for several weeks, completely relieved the attack. Each injection was followed by relief and the disease disappeared entirely, leaving her in better condition, according to her own statement, than she had ever been in since it first occurred. From his experience in this case, Cuthbertson would recommend sodium cacodylate injections for trial in all cases of erythema, more especially in the angioneurotic type.—*The Medical Brief*.

SPINAL CORD TUMORS.

Flateau, who has had comparatively abundant opportunity for observing these cases, finds the operative mortality about 50 per cent, due to faulty technique, septicemia, and a group of causes little understood and probably due to operative traumatism. Much effort has been made to develop the differential diagnosis between intra and extramedullary growths. Nonne concludes that a strong phase-one reaction and an absent lymphocytosis

cannot be used to differentiate between these growths. The X-ray is of little value in the diagnosis of tumor of the cord. If, however, the spinal column is also involved by the growth, much help may be obtained. The territory embraced in the cauda equina, says Schwab, is still a region full of diagnostic pitfalls. Not only is localization here extremely difficult, but operation is accompanied by high mortality. Further study of these cases, especially the microscopic study of such cases as come to autopsy, may add to our knowledge.—(S. I. Schwab, *Interstate Medical Journal*.)—*The Alienist and Neurologist*.

A CASE OF TUBERCULAR PERITONITIS: PROLONGATION OF LIFE BY INTRA-ABDOMINAL ADMINISTRATION OF OXYGEN.

Dr. Meeker showed a case of tubercular peritonitis which he had treated by the intra-abdominal administration of oxygen. The case was apparently cured. He also advocated its use in cases of profound shock and ascites, and said that it required from seventy-two hours to four or five days for complete absorption. Care had to be exercised in watching cases, as the abdomen became flat in from forty-eight to seventy-two hours. Collapse from its complete absorption should be guarded against by the free administration of stimulants. Dr. Bainbridge said he had been using oxygen to meet shock in abdominal surgery for the past eight years, and had treated in all about one hundred cases. He had noted marked improvement and a ready response to its use.—*Texas Medical Journal*.

SYPHILITIC AORTITIS.

Goldscheider (*Med. Klinik*, No. 12, 1912), in "Ueber die Syphilitische Erkrankung der Aorta," contends that the condition of syphilitic aortitis or mesaortitis is much more common than generally believed, and he urges its wider recognition. Out of ninety-seven cases of syphilitic disease of the circulatory system, fifty-six cases were definitely confined to the aorta, thirty-seven cases showed a general arteriosclerosis, four myocarditis. Of the fifty-

six cases of aortic disease, twenty-one occurred without aneurysm or an insufficiency of the aortic valves, and therefore depended largely for their recognition upon certain enumerated symptoms and signs. The X-ray is a refinite aid in aneurysm and dilatation of the aorta and almost indispensable in recognizing the dilatation of the descending aorta. The Wassermann reaction has been of infinite benefit in confirming the diagnosis of syphilitic aortitis.—*The Lancet-Clinic*.

THE USE OF CACTUS IN EPILEPSY.

Here is a new one about cactus, and yet not so either, for the argument was perfectly sound and had occurred to others before now. Dr. N. W. Dewees reports (*Eclectic Medical Journal* for April) five cases of epilepsy, all in men between thirty and fifty-eight years of age, who had been suffering from epilepsy for years and who showed the unfavorable mental effects of the disease. Reasoning that, if cactus would control the nerve-force in functional disturbances of the heart, it would also control functional disturbances of the brain, the doctor put his idea to the test. He says that he has proved the soundness of it many times in the treatment of patients threatened with insanity, and is confident that cactus has saved more than one of his patients a trip to the madhouse. In his judgment, cactus equalizes the nerve force in the body, promoting normal functional activity of the heart and brain. We should like reports of this use of cactus, or cactin, from our readers.—*The Am. Journal of Clinical Medicine*.

OBSTETRICAL

MENORRHAGIA IN YOUNG GIRLS.

According to *Folia Therapeutica* for October (1911), Dr. Goerl recently reported to the Nuremberg Medical Society two cases of profuse menstruation in young girls, in whom examination failed to reveal any anatomical cause for the menorrhagia, and who were rapidly and thoroughly cured by exposure of the

abdomen to the Roentgen rays. Dr. Goerl suggests that the rays act on some toxin in the circulation, a substance which is allied to the normal internal secretion of the ovary and which is responsible for normal menstruation. He is, however, unable to explain the precise way in which X-rays affect the ovarian secretion.—*The American Journal of Clinical Medicine*.

LOCAL ANESTHESIA OF THE UTERUS WITH COCAINE.

F. Febres advocates the performance of many operations on the cervix, both in gynecology and obstetrics, with local anesthesia by means of cocaine. The application of the cocaine is interstitial, and is made by four injections into the cervical tissues: in front, behind, and on the sides, with an amount of solution which will equal four centigrams of cocaine. In four or five minutes there is perfect local anesthesia. This method is applicable in all operations on the cervix: repair, incision of cysts, dilatation for treatment, curettage, and prolapse operations may all be done in this way. After labor the removal of adherent membranes and dilatation for rapid evacuation of the uterus may be done.—*Medical Record*.

BLOOD PRESSURE INDEX OF ECLAMPSIA.

H. C. Bailey (*Surg., Gyn. and Obstet.*, 1911, xiii, 505) states that the average blood pressure in the last weeks of pregnancy is 118 m.m. of Hg. Fluctuations amounting to 30 m.m. of Hg. above this need cause no alarm. Blood pressure over 150 should be thoroughly investigated at once. Blood pressure in eclampsia, with convulsions, though usually in the neighborhood of 200 m.m. of Hg., may be as low as 155 m.m. Convulsions do not occur when the blood pressure is lowered by poor resistance, as in the so-called fulminant cases or when lowered by veratrum viride or other drugs producing collapse. Treatment should be directed, not toward reducing the blood pressure, but to the treatment of the toxemia, for the rise of blood pressure may denote only the resistance of the system toward toxins. Tri-weekly blood pressure examinations, combined with regular urine examinations

for albumin and casts, offer the best safeguard against the unexpected pressure of this disease.—*New Orleans Medical and Surgical Journal*.

DIRECT BLOOD TRANSFUSION IN A CASE OF RUPTURED
ECTOPIC GESTATION.

Dr. John O. Polak reported the case of a woman, 26 years of age, whose first symptoms referable to ectopic gestation occurred on September 6, 1911. On October 2, and again on October 13, there were symptoms of possible ruptured ectopic gestation. On November 6, on account of localized pain in the right lower quadrant of the abdomen she was operated upon by Dr. Polak and a large hematocele was revealed and evacuated. A three months' fetus was found floating free among the intestines in the right renal region. The placenta was attached in the right tube. After securing the points of hemorrhage the abdomen was closed. About eight hours after the operation there were symptoms of secondary hemorrhage and the abdomen was reopened but no bleeding point was found. The abdominal cavity was filled with free serum. While the incision was being closed Dr. Brinsmale exposed the right saphenous vein, and Dr. Bristow inserted the right radial artery of her husband into the vein, completing an anastomosis. The transfusion of blood thus made possible was continued for one hour. The effect was magical; the pulse slowed and became fuller, the lips became rosy, and the hemoglobin index rapidly increased. The operation was followed by a perfect recovery.

The points of interest illustrated in the case are first, that hydremic patients stand shock badly and are made worse by the intravenous use of saline solution. Second, that it is difficult to differentiate shock from hemorrhage in patients with low red cell resistance. Third, the marked benefit of direct blood transfusion.—*Long Island Medical Journal*.

ADRENALIN IN HYPEREMESIS GRAVIDARUM.

Robinson recently presented to the Academie des Sciences a very remarkable contribution to the study of the relationship be-

tween the suprarenals and the gravid state, also their use in hyperemesis gravidarum.

His article was based upon two very interesting cases. One patient vomited so severely that she could not take any kind of food. Ten drops of 1-100 solution of adrenalin was administered. The first day the vomiting ceased and the patient began to eat. She stopped the drug after three weeks and the vomiting started afresh, but returning to the adrenalin it ceased. After continuing this treatment for several months she was delivered of a healthy child. The second case was almost same as the first.

These two cases show that there is an intimate relationship between the adrenals and the genital glands. The pigmentation of the skin, the rebellious vomiting and the lassitude of Addison's disease is often met with in certain cases of pregnancy to which we refer. The author wishes to interpret these manifestations accordingly: the products of the adrenals and the genital glands neutralize each other in the normal state, but when one of the two products becomes exceedingly active, the other becomes fatally reduced unless substituted by the vicarious organ.

We know the beneficial effect that adrenalin has upon osteomalacia, which is likewise slightly relieved by removal of the ovaries. There is no doubt a synergistic action between the two functions.—*La Tribune Medicale*.

PITUITARY EXTRACT IN OBSTETRICS.

After using intramuscular injections of pituitary extract in a large number of cases the author concludes that the best time to administer the drug, in the first stage of labor, is when the os is a little less than the size of the palm, in primiparæ, and when it will just admit two fingers, in multiparæ. If given at a time when pains have not yet appeared its effects are but temporary and ineffective. But if given later, its action, which begins to show itself in three minutes, induces powerful, frequently repeated uterine contractions for about ten minutes; during this time the uterus remains in partial contraction in the intervals between pains. Later, the effect gradually diminishes, disappearing in an hour. The power of the contractions induced by full doses

is shown in that the fetal heart rate may be more or less markedly reduced.

Employed in the period of expulsion of the fetus, pituitary extract, according to the author, will in many instances render the application of forceps unnecessary. Its use is clearly indicated in secondary uterine inertia and in cases where, owing to undue enlargement of the uterus because of hydramnios or twin pregnancy, the pains are ineffective. In febrile states it may also be employed. Where complications are expected after the birth of the child, an injection of pituitary extract a few minutes before the end of the second stage is to be recommended. On the other hand, if the birth of the child does not take place until about an hour after the injection, a possible hemorrhage is to be feared, and the patient must be closely watched.—F. Jaeger (*Münchener medizinische Wochenschrift*, February 6, 1912).

Another observer writes concerning the effect of pituitary preparations (puitritin in particular) in the early months of pregnancy, when, in the treatment of cases of abortion, local intervention in the form of curettage is considered inadvisable, and a remedy is desired which will limit absorption by firmly contracting the uterine wall and tend to expel the fetal remains. He found that, because of the less irritability of the uterus early in pregnancy, the results of puitritin injection were much inferior to those obtained later, and were no more certain than those of ergot or of hot and cold vaginal douching.—L. Hell (*Münchener medizinische Wochenschrift*, December 12, 1911).

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at \$1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

SUICIDE.

In this era of preventive medicine in which so much has been accomplished in the fight against disease and death, some steps should be taken to prevent death by suicide, and the medical profession, especially the neurologists, should lead the fight. The neurotic type can be found throughout the civilized world, but nowhere in such numbers as in America, where everybody leads the strenuous life. Some seem to feel no evil effects from the constant strain, but most of us do, and even though we ourselves escape, our descendants are apt to be streaked with some neurotic stripes. Suicides are usually neurotic and unbalanced, and so can not view the world like a normal man. Since they are neurotic they are impressionable, and everything possible should be done to prevent wrong impressions developing in fertile soil.

The newspapers, with their vivid and minute descriptions of suicides are responsible for many of the annual number of suicides in America, and for that matter throughout the world. Suicide is a crime, and like other crimes it should be recorded only and not be made the leading article of the day's news. All crimes would decrease in number, and especially suicides, were it the custom to devote only a few necessary lines to the facts. All descriptions of the criminal should be confined to his name and occupation. Suppositions as to cause, letters left behind, his actions immediately preceding death, etc., often make the suicide a martyr or hero, and we all know that he is seldom either. These yellow journal descriptions appeal to the minds of other neurotics, and so they, too, commit suicide. Why such is the case nobody knows, but it is a fact that crimes in one part of a country are

followed by similar crimes in distant sections of the same country, sometimes even in foreign lands. Although the automobile bandits in Paris finally came to grief, yet already they have had their imitators. Some of these imitators have been nothing more than children. The negro fiend usually pays for his crime almost as soon as it's committed, and yet these crimes are epidemic in certain sections.

Freedom of the press is something we all desire, but when this freedom destroys the homes and happiness of others it should be checked, and it will be checked. The question is, When?—W. T. B.

JOHN A. WITHERSPOON, M.D.

At the annual meeting of the American Medical Association in the early part of this month, Dr. John A. Witherspoon, of Nashville, Tenn., was chosen president. We wish to congratulate Dr. Witherspoon for winning this honor, and at the same time the American Medical Association for choosing one so eminently qualified for this honorable position. Nashville has given four presidents to this association: Drs. Paul F. Eve, W. K. Bowling, W. T. Briggs and John A. Witherspoon. This is a large percentage for a city the size of ours, and we can not help feeling proud of the local profession which proves itself worthy by producing such men as these. We trust that the future will produce others from Nashville qualified for this honor, but feel sure that none will grace the office better than those who have gone before, and the present incumbent.

LISTER'S LEGACY.

The legacy to the human race of the beneficent discovery of antiseptic surgery were legacy enough, a legacy which would never cease to benefit the legatees and go on accruing in value till time is no more. Yet it is fortunate that Lister was through all his life able to make shillings subservient to science illings. You have all heard of John Hunter's exclamation when called from research to the realities of life: "I suppose I must go and earn this d—d guinea, or I shall be sure to want it tomorrow."

Had Lister been interrupted under the same need which Hunter was we can not imagine him using the same forceful language, yet fortune had provided kindly for Lister and practice was secondary to science in his case. It is a question often whether want stimulates scientific investigation or not. Probably it depends more on the man than his money, though money is a valuable adjunct and becoming more so. Lister's whole life was one of kindness and consideration. What else could you expect of the man who said that kindness of heart is the first requisite for a surgeon. It is not therefore surprising that Lister left the bulk of his estate, 65,000 pounds, for the benefit of mankind and the furtherance of research directed towards the discovery of the means of the prevention and the cure of disease. His career was consistent from first to last, and the disposal of his estate shows that his devotion to that greatest of all human endeavor was strong—even in death. Always a modest, kind and considerate gentleman, who loved his fellowmen. Such titles as Professor, Sir and Lord seemed so superfluous to Lister.—E. S. McK.

STATE FAIR.

Attention is called to the advertisement of the State Fair in another part of this paper.

The fair this year will be State-wide in every particular, and educational in every feature.

\$30,000 will be given in premiums for Live Stock, Field Products, Garden Products, Orchard Products, Dairy Products, etc.

Everything well cared for in liberal premiums.

Boys' Corn Clubs and Girls' Tomato Clubs have been provided for in the catalogue, which is being distributed free.

All you have to do is to write for one.

A free trip for some boy from every County in the State. Write for particulars. You may be the boy selected, and you will be given a free trip to the fair, and can remain for one week without having to spend a cent for railroad fare, board, and other expenses necessary for such a trip.

The amusement features will be high-class: Fireworks every night. Night horse show. Races every afternoon. Free acts

afternoons and evenings. Three brass bands in concerts three times daily. Best of all, the railroads will grant low rates to see the big fair.

GRADUATION EXERCISES.

The annual graduation exercises of the Vanderbilt Medical School were held Tuesday evening, May 21, in College Hall on the west campus. There were sixty-six graduates, which is the largest number for some years. Dr. M. C. McGannon delivered the faculty address.

Dr. Dudley, Dean of the Medical Department, awarded the scholarships and the Founder's Medal. William Bell Goddard, Kentucky, was the winner of the scholarship in the first year class; Raymond Myers Evans, Kentucky, winner in second year class; Joe Davis Applewhite, won it for the third year class, and Dr. Andy Anderson Eggstein, Tennessee, won the Founder's Medal.

About half of the class received hospital appointments in the different hospitals throughout the country.

Reviews and Book Notices

Progressive Medicine (Awarded Grand Prize, Paris Exposition, 1909).—

A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; One Time Clinical Professor of Diseases of Children in the University of Pennsylvania; Member of the Association of American Physicians, Etc. Assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson College, Philadelphia; Ophthalmologist to the Frederick Douglass Memorial Hospital; Instructor in Ophthalmology, Philadelphian Polyclinic Hospital and College for Graduates in Medicine. Volume II. June, 1912. Hernia—Surgery of the Abdomen, Exclusive of Hernia—Gynecology—Diseases of the Blood. Diathetic and Metabolic Diseases. Diseases of the Spleen, Thyroid Gland, Nutrition, and the Lymphatic System—Ophthalmology. Lea & Febiger, Philadelphia and New York, 1912.

Our thanks are due the publishers for the current number (June), of this excellent quarterly publication. It is an unusually

interesting number and compares favorably in all respects with the foregoing issues of this valuable serial. The contents of this number are as follows: Hernia, by William B. Coley, M.D., New York City; Surgery of the Abdomen, Exclusive of Hernia, by John C. A. Gerster, M.D., New York City; Gynecology, by John G. Clark, Philadelphia, Pa.; Diseases of the Blood, Diathetic and Metabolic Diseases, Diseases of the Thyroid Gland, Nutrition and the Lymphatic System, by Alfred Stengel, M.D., Philadelphia, Pa.; Ophthalmology, by Edward Jackson, M.D., Denver, Colo.; Index. It may be seen from this table of contents and the list of distinguished authors that a variety of interesting subjects is presented, and that the very latest views upon these subjects are given in the most interesting way. The paper upon Hernia is especially valuable, written by a man of world wide reputation for his experience in this particular disease. In commending this excellent quarterly to our readers we urge upon every physician to subscribe to the work, assuring him that he can get knowledge in this way what he could only require by laborious research through current medical literature. The work of these contributors insures a true harvest in which the chaff has been removed and the true grain remains.

Publisher's Department

THE PREVENTION OF DYSMENORRHEA.

How can we prevent dysmenorrhea? It can be done by keeping the patient under morphine, but this is a barbarous solution of an important problem. It in fact does not solve it. Morphine is inadmissible and improper in these cases. It produces derangement of the secretions and tends to establish a drug habit that will make life a burden. I have long employed a remedy that not only relieves the pain, but produces no habit, and is not dangerous. I refer to Dioviurnia. It is a most valuable uterine tonic, antispasmodic and adoyne of exceptional worth. I rely upon this remedy to prevent dysmenorrhea, which, as Professor Davenport truly says, is seen in almost all, if not all, women. I have my patients, who suffer with dysmenorrhea to take Dioviurnia, beginning

two days before menstruation is due and persist in it until the period has passed. I give it in doses of one to two teaspoonfuls every three hours throughout this time. When this direction is followed I have found that my patients go through the period without pain. The adoption of this treatment I may say, also, has brought me many grateful compliments.

Where the patient is very nervous, having the tendency to hysteria, neuroses or uterine congestion, I administer Neurosine one part, in combination with two parts of Dioviburnia, which always gives relief.—L. G. Boyd, M.D.

GLYCO-THYMOLINE IN CHOLERA INFANTUM AND SUMMER DIARRHOEA.

Henry Koplic, M.D., Attending Physician at Mount Sinai Hospital, in his recent excellent work upon "The Diseases of Infancy and Childhood," in discussing the treatment of cholera infantum, says:

"The diarrhoea is controlled by irrigation of the gut. The rectum and gut are washed out in those cases in which the diarrhoea is not only persistent, but progressive. The object in washing out the lower bowel in any form of acute gastro-enteritis is two-fold: (a) To remove any residue of feces that may have collected in the lower bowel and rectum, and to stimulate peristalsis and thereby favor evacuation from above. (b) To stimulate the heart and add to the body an amount of normal solution to compensate for the drain caused by the diarrhoea.

"The rectal enemata are given under a pressure obtained by an elevation of at at most, two feet from the body. A temperature of 107° to 110°F. (40.5° to 43.3°C.) is the best and most stimulating in these cases. Fully a quart of water is thrown into the rectum in half pint portions. As the half pint flows in, the funnel of the rectal tube is disconnected and the contents of the bowel is allowed to escape. Another portion is then allowed to flow into the bowel. The water will sometimes escape alongside of the tube. This is rather a favorable sign, being significant of the contractile powers of the gut and abdominal walls. Only two enemata daily are necessary, even in severe cases of acute gastro-enteritis. As the diarrhoea and symptoms subside, we reduce the number of enemata to one."

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NASHVILLE JOURNAL — OF — MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

VOL. CVI.

JULY, 1912.

No. 7.

Original Communications

ANNUAL REPORT OF SURGICAL OPERATIONS AT
THE PRIVATE INFIRMARY OF DRS. CHARLES S.
AND SAMUEL S. BRIGGS DURING ITS TWENTY-
FIRST SEASON, FROM SEPTEMBER 10, 1911, TO
AUGUST 1, 1912.

REPORTED BY W. T. BRIGGS, M.D., NASHVILLE, TENN.

With August 1, the twenty-first year of Briggs Infirmary closes for one month to reopen for its twenty-second season September 10, 1912. This annual report is issued in order that the profession of the South and West may see the character of work done, and the results obtained in this institution. The surgical operations performed and the methods of treatment adopted have been characterized by the closest attention to the requirements of modern surgery, and the results obtained have been, in all cases, extremely gratifying. Only one death has occurred, and that was in a case of inoperable abdominal sarcoma, in which an exploratory operation was done. The anæsthetic employed in most cases has been the A. C. E. mixture, though chloroform was occasionally resorted to. Post-anæsthetic nausea was prevented to some extent by the administration of large doses of chloretone given some hours before operating. In some of the most recent cases, experimentation has been made with hypodermic doses of the synthetic preparation, heroin, to prevent this complication, and, as it is thought, with some degree of success. The anæsthetists—Dr. H. S. Jeck and Dr. W. T. Briggs—have invariably used the

open method of anæsthetization with the Esmarch mask. The preparation of dressings, catgut, etc., and the superintendence of nurses has been in the hands of the excellent head-nurse, Miss M. M. Sproull. Only the operations and methods have been reported that are supposed to be of interest to readers, as many operations of minor character have been omitted. Again, we take occasion to thank our professional friends for their generous patronage in the past and to bespeak a continuance of the same for the season of 1912-1913.

Case No. III. Curettage for Chronic Endometritis. Mrs. L. B. R., æt. 27 years, Madisonville, Ky., entered September 6, for treatment of chronic endometritis, with the concomitant symptoms of menorrhagia, mucorpurulent discharge, etc. Under A. C. E. anæsthesia, September 7, the os was freely dilated, the uterine cavity thoroughly curetted with sharp and dull curettes and the cavity packed with gauze after swabbing it out with strong solution of iodine and carbolic acid. The uterine mucosa was treated every other day with tincture of iodine, and the patient was dismissed in ten days.

Case No. IV. Abdominal Sarcoma—Laparotomy. T. R. R. æt. 6 years, resident of the city, entered September 8. The patient had been suffering for several months with pressure symptoms from an enlargement occupying the lower half of the abdominal cavity, viz.: constipation, hæmaturia, painful micturition and reflex gastric disturbances. The swelling was prominent, dull on percussion and smooth over its surface. September 10, under chloroform, the tumor was exposed by four-inch median incision, and was found to be closely adherent to the intestines and bladder, some of the former seeming to be incorporated with the neoplasm. The central presenting part of the tumor offered a soft area; this was incised, evacuating fecal matter, showing involvement of the bowel. After inserting in this cavity a drainage tube and closing the parietal wound around it, the operation was abandoned. The patient died of inanition October 1. Post-mortem showed that the removal of the tumor was impossible, as it had involved in its growth everything in the lower abdomen.

Case No. V. Removal of Adenoids. E. G., æt. 9 years; admitted September 10, for relief of adenoids. The usual symptom presented and the necessity for operation was obvious. Under chloroform anæsthesia the day of admission, the adenoids were thoroughly removed with the adenoid curette. Relief was immediate, and the patient returned home the day of the operation.

Case No. VII. Laceration of the Cervix—Trachellophary. Mrs. G. W. M., Davidson County, Tennessee, æt. 32 years; entered September 15, for treatment of uterine lesion following childbirth. Examination showed extensive bilateral laceration of the cervix. The patient presented the usual symptoms incident to such lesions, the predominant ones being those of nervous character. Under A. C. E., September 16, the clefts were freely pared and sutured with No. 2 cat-gut sutures, three on one side and four on the other. Union was perfect, and the patient was dismissed in two weeks.

Case No. X. Sarcoma of the Breast—Amputation. Miss M. M., æt. 46 years, Nolensville, Tenn., was admitted September 20, for treatment of mammary tumor. The left breast was the seat of the growth, which was larger than a man's head, hard and irregular over its surface, and presented an ulcerated area over the upper lateral aspect, which constantly bled rather profusely. There was no enlargement of the axillary glands. Under A. C. E. anæsthesia, the breast was excised between elliptical incisions and the axilla explored for glands negatively. A large portion of the pectoralis major muscle, including its fascia, was removed with the tumor. The wound was closed throughout the greater part of its extent, but a considerable space was left to heal by granulation owing to the immense volume and extent of the growth. Healing took place slowly and in a short time recurrence occurred in the granulating area to which caustic applications were made. The patient went home with the wound still granulating.

Case No. XII. Varicocele—Open Method of Excision of the Veins. T. L. B., æt. 26 years, Columbia, Tenn., entered September 20 for treatment of large varicocele of the left side. The

veins were very large and numerous, making a considerable tumor. The testicle of that side was considerably atrophied and the patient suffered the usual dragging pains which a suspensory only partially relieved. Under A. C. E. anæsthesia, the veins were exposed by a vertical incision, isolated from the vas deferens and ligated at an interval of an inch, the veins excised and the ends of the ligatures tied so as to anastomose the stumps. The skin wound was sutured transversely so as to shorten the scrotum. Healing was satisfactory and the patient went home October 2.

Case No. XIII. Curettage, Following Abortion at Three Months. Mrs. W. T. M., æt. 32 years, Davidson County, Tennessee, was brought to the Infirmary September 20 for relief of sapremic symptoms following self-induced abortion. The patient had passed part of the uterine contents prior to admission, but had had a chill with subsequent elevation of temperature, and a copious, offensive smelling flow. Under A. C. E. anæsthesia, September 21, the os was fully dilated and the cavity of the uterus thoroughly curetted with both sharp and dull curettes, removing quite a quantity of partially decomposed tissue. The cavity of the uterus was swabbed out with strong tincture of iodine and packed with gauze. Recovery was rapid and the patient returned home October 5.

Case No. XV. Necrosis of the Femur—Curettage of the Bone. A. R., æt. 19 years, Mt. Pleasant, Tenn., entered September 18, for treatment of dead bone in lower fourth of the femur just above the knee-joint, very likely of tuberculous origin. A fistulous orifice was located just above and to the outer side of the knee, from which there was constantly discharged a characteristic fluid. Through this a probe came readily in contact with dead bone. The knee was greatly enlarged and the joint partially ankylosed. Under A. C. E., Sept. 30, the femur was exposed by four-inch vertical incision on the outer side and the diseased bone scraped vigorously with the sharp bone curette. The cavity was dressed with gauze soaked in balsam Peru. The granulation process gradually filled the space, but at no time covered the bone.

The subsequent progress of this case is described later in the report.

Case No. XVIII. Recurrent Sarcoma—Excision. Miss M. D., æt. 42, Nolensville, Tenn., reëntered October 2, for removal of unusually rapid recurrence of growth in the granulating area of operation wound as described in Case No. X. Under A. C. E. anæsthesia, October 3, the fungating masses, which had sprung up in the open area, were excised down to the ribs, removing at the same time a considerable portion of the muscles. The parts seemed to take on favorable action for a time though progress was slow. The X-ray was used without apparent effect. The patient went home in three weeks without improvement.

Case No. XX. Chronic Appendicitis—Appendectomy. Miss A. T. W., æt. 26 years, Jordonia, Tenn., entered October 3, for treatment of persistent pain in right iliac region and evidences of catarrhal colitis. The patient was dyspeptic and at times suffered exacerbations of the pain in her appendical region. Menstruation was undisturbed. Examination showed marked tenderness at McBurney's point, and palpation a deep seated induration at the site of the appendix. Under A. C. E., October 4, the peritoneal cavity was opened by a three-inch incision in the right linea semilunaris and the appendix delivered and removed. The stump was invaginated with a purse string suture. The wound was closed in the usual manner. The appendix was thickened and markedly clubbed at its distal extremity. The sutures were removed on the 7th day and the patient was dismissed on October 20.

Case No. XXI. Fistula in Ano—Incision. J. T. H., æt. 41, Cross Plains, Tenn., had for several years been troubled with anal fistula following a peri-rectal abscess, which had evacuated itself spontaneously. Examination October 3, disclosed three fistulous orifices situated at varying distances from the anus. The probe passed clearly through one of these into the rectum and through the other two could be passed into the main channel. Under A. C. E. anæsthesia the day following admission the main fistulous tract was divided on a grooved director into the

rectum, and the others laid open into the first incision. The fistulous tracts were thoroughly curetted and packed with gauze. The parts granulated and filled up rapidly and the patient was dismissed October 14.

Case No. XXII.—Stone in the Bladder—Medo-Bilateral Lithotomy. J. S. D., æt. 35 years, from near Bolivar, Ky., entered October 6 suffering from vesical symptoms, indicating the presence of stone in the bladder. The cardinal symptoms of stone, frequent and painful micturition increased on exercise, and hematuria nearly always present, were prominent, and the stone searcher introduced into the bladder came at once in contact with the stone. After several days of preparatory treatment, on October 9, under A. C. E. anæsthesia, perineal lithotomy after the medio-bilateral method was done and a spherical one-ounce phospho-urate stone was extracted. Very little blood was lost. A perineal tube was carried through the wound into the bladder, and a loose packing of gauze inserted around the tube. These were removed after twenty-four hours. The patient did well, passing his urine *per vias naturales* on the twelfth day, and was dismissed October 30.

Case No. XXV. Ovarian Cystoma—Ovariectomy. Mrs. D. H., æt. 42 years, northern Alabama, near Guntersville, entered October 10, for relief of abdominal tumor of several years standing. Examination disclosed symmetrical enlargement of the abdomen as large as a full-term pregnancy. The history of its beginning on her left side, dullness on percussion, distinct fluctuation, all the symptoms accentuated by a well-marked *facies ovariana*, indicated clearly ovarian cystoma, growing from the left ovary. Under A. C. E. anæsthesia, October 13, the cyst was exposed by a four-inch median incision, the fluid evacuated with a Spencer-Wells trochar, and after ligation of the pedicle with silk braid ligature, the cyst was removed. The parietal wound was closed with through and through silkworm gut sutures, tied after serial cat-gut suture of the peritoneum and fascia. The cyst was unilocular and contained nearly two gallons of straw-colored fluid. The wound healed perfectly and the sutures were removed on the eighth day. The patient was dismissed November 4.

Case No. XXVIII. Talipes Equino-Varus—Phelp's Operation. John D. H., age $2\frac{1}{2}$ years, from near Dresden, Tenn., presented October 16, with double equino-varus. Efforts had been made some months previously to correct the deformity by tenotomy and braces, but with no improvement of his condition. October 17, under chloroform, the medio-tarsal joint in each foot was laid open by free incision on the inner side of the foot after the tendo Achillis had been subcutaneously divided. All constricting bands were divided so that the feet could be forced into an over-corrected position. The wounds were packed with gauze, and both feet in over-corrected position, were encased in plaster of Paris bandage. The first dressing was done on the fourteenth day, and the large gaps found nearly filled up. A light brace was adjusted and the patient returned home November 10 with the deformity entirely relieved.

Case No. XXIX. Adenoma of Mammary Gland—Excision. Miss H. T., æt. 19 years, city, entered October 20, for removal of small tumor of the left breast. The tumor was about the size of a guinea egg, in the upper external quadrant of the breast. It was hard, movable under the skin and painless. Under A. C. E. anæsthesia the growth was exposed by a two-inch incision, radiating to the nipple, and was enucleated with very little trouble. The wound, closed with continuous cat-gut suture, healed rapidly and the patient was dismissed on the sixth day.

Case No. XXXI. Internal Hemorrhoids—Ligation. J. D. T. æt. 36 years, Portland, Tenn., entered October 26, for treatment of internal hemorrhoids of several years standing. Examination disclosed a ring of large nævoid masses, which protruded at stool, and bled to such an extent after defecation as to keep the patient in an exsanguinated condition. Under A. C. E. anæsthesia, October 27, the rectum was freely dilated and the masses, four in number, each transfixed and ligated in halves, after which they were excised. The patient made a rapid recovery and went home November 6.

Case No. XXXIII. Cystic Degeneration of the Testicle—Castration. R. D., æt. 41 years, Mt. Juliet, Tenn., entered November

1, with enlargement of the right testicle. The tumor was as large as the fist, hard, rather irregular over its surface, ovoid in shape and only slightly tender upon pressure. The enlargement had begun three years previous, and was due to traumatism. Under A. C. E. anæsthesia, November 2, the testicle was removed through a vertical incision and found to be of cystic nature. The wound healed without accident, and the patient was dismissed November 11.

Case No. XXXVI. Laceration of Cervix and Perineum — Trachellophary. Mrs. C. B., æt. 29 years, Alexandria, Tenn., entered November 6 for treatment of laceration of cervix and partial laceration of the perineum. Under A. C. E. anæsthesia, November 7, the cervix was repaired, using No. 2, twenty-day cat-gut, and the perineal laceration was repaired after the method of Dudley, using silkworm gut deep sutures and catgut superficial. Complete healing followed and the patient was discharged November 26.

Case No. XXXVIII. Complete Laceration of the Perineum. Mrs. P. W. D., æt. 37, Tennessee City, Tenn., entered November 15 for treatment of complete laceration of the perineum. The lesion was produced at the birth of her last child two years previously, and was attended with the usual unpleasant symptoms incident to that condition. November 16, under A. C. E. anæsthesia, the parts were repaired after the method described by Dudley silkworm gut sutures being used for the deep sutures, and No. 1 ten-day cat-gut for the superficial. Healing was perfect, and there resulted complete restoration of the sphincteric function. The patient was dismissed December 4.

Case No. XL. Pancreatitis—Laparotomy.—W. A., æt. 34, Nashville, Tenn., entered November 20 for treatment of tumor in the right hypochondriac region extending into the epigastric. The diagnosis was doubtful, though a pear-shaped tumor, with its axis horizontally placed, presented in the region of the gall-bladder, and there was apparently enlargement of the left lobe of the liver. The patient had suffered with almost constant colicky pains in this region and some tenderness, but at no time

was there jaundice or elevation of temperature. The stools were of proper color. The indications pointed to involvement of the pancreas. November 22, under A. C. E., the cavity was entered by four-inch vertical incision through the right rectus muscle. The liver and gall-bladder were found normal. The foramen of Winslow was occluded. The pancreas was greatly enlarged, hard and somewhat nodulated. Only slight evidence of peritonitis. Some adhesions were broken up and a tubular drain inserted. The parietal wound was closed in the usual manner. The patient recovered rapidly from the operation and has apparently been relieved of all his symptoms.

Case No. XLIII. Chronic Appendicitis.—Appendectomy. H. B., æt. 28, Gallatin, Tenn., admitted November 25, with symptoms of chronic appendicitis. Occasional sharp attacks of pain and tenderness in the right iliac region. Some evidence of deep-seated induration at the site of the appendix. Under A. C. E., November 26, the cavity was opened by three-inch incision in the right linea semi-lunaris, the appendix found, delivered and excised and the stump buried with purse-string catgut suture. The parietal wound was closed as described in former cases. The specimen was found inflamed and thickened, and its mucosa infiltrated. Rapid recovery followed and the patient was dismissed December 14.

Case No. XLV. Radical Cure of Femoral Hernia, and Operation for Varicocele. J. W. E., æt. 30, Memphis, Tenn., admitted December 1, for treatment of femoral hernia and of varicocele. Under A. C. E., December 2, the hernial sac was exposed by oblique incision three inches in length below and parallel with Poupart's ligament. Burns' ligament was bared and the cribriform fascia opened. The hernial sac contained omentum, which was excised after ligating with a double ligature passed through it and the neck of the sac. The canal was closed with catgut sutures passed through Burns' ligament to the fascia covering the pectineus muscle. The cutaneous wound was closed with continuous catgut suture. The varicocele was exposed by vertical incision, the veins isolated from the vas deferens and ligated with strong catgut at two points an inch apart, the mass of veins ex-

cised and the stumps joined by tying the respective ligatures together. The patient made an excellent recovery and was dismissed December 16.

Case No. XLVI. Stricture of the Urethra—Internal Urethrotomy. H. B., æt. 33 years, Chattanooga, Tenn., entered December 8, for treatment of urethral stricture of long standing. The principal stricture was located with the *bougies a boule* in the bulbous urethra, admitting with difficulty a No. 12 American gauge sound. The size of the urinary stream was much reduced, and the frequency of micturition annoying. Under A. C. E. anæsthesia the day of admission, the stricture was freely divided with the Otis urethrotome and a number twenty sound, American scale, readily passed into the bladder. Dilatation with sounds was kept up every other day for ten days and the patient was dismissed December 20 with instruction to pass the sound once a week.

Case No. XLIX. Acute Suppurative Appendicitis—Appendectomy. C. D., æt. 20 years, Alexandria, Tenn., was brought to the Infirmary December 23, with severe acute suppurative appendicitis. Under A. C. E. soon after admission, the cavity was opened by three-inch incision in the right semilunar line, evacuating several ounces of four smelling pus. The pus cavity was well walled off. The appendix was gangrenous and perforated. It was removed and its stump buried in the usual manner. A rubber drainage tube was inserted into the cavity through a stab made at the triangle of Petit. Troublesome hemorrhage occurred from needle wound of the deep epigastric artery. Through and through sutures of silkworm gut were placed but not tied, and the wound was packed with four strips of gauze. The sutures were tied on the 10th day. Convalescence was slow, but perfect, and the patient was discharged February 15.

Case L. Multiple Uterine Submucous Myomata—Hysterectomy. Miss M. C., æt. 26 years, Hartsville, Tenn., entered December 23 for treatment of uterine myomata. Constant metrorrhagia had very considerably reduced the patient. Tumor in the median line showed up above the pubes. The probe indicated in-

creased depth of the uterine cavity. Under A. C. E. anæsthesia, December 28, a six-inch incision in the linea alba was made and the uterus lifted out of the cavity. The vessels were secured on each side with ligatures of Pachenstecher's thread and the cervix divided. The cervical stump was sutured from before backwards and the peritoneum closed from side to side with continuous catgut suture. The parietal wound was closed in the usual manner. The specimen presented multiple fibromata with one large tumor occupying the cavity of the uterus. The patient made an uneventful recovery and was dismissed January 23.

Case LII. Chronic Recurrent Appendicitis—Appendectomy. Miss E. C., æt. 25, Belleview, Tenn., entered January 10, with chronic appendicitis. The patient had suffered a number of very severe attacks, from the last of which she had just recovered. The usual symptoms of chronic appendicitis were present. January 12, under chloroform anæsthesia, the appendix was removed through a three-inch incision in the right semilunar line and the stump buried with purse-string suture of catgut. Unusual difficulty was experienced in delivering the appendix on account of close adhesions. Recovery was uneventful and the patient returned home February 7.

Case No. LV. Amputation of Thigh for Tubercular Knee-joint. A. R., æt. 19 years, Mt. Pleasant, Tenn., upon whom operation for dead bone was described in Case No. XV. The patient's condition not having improved from the previous operation, it was decided to amputate the thigh. Accordingly, January 15, under A. C. E. anæsthesia, the thigh was amputated at the junction of the middle with the lower third, the section of the bone being made above the diseased part of the bone. The amputation was made by the antero-posterior method, the anterior flap being made by dissection and the posterior by transfixion. The muscles were united by deep-buried sutures of catgut and the wound closed without drainage with alternate sutures of silkworm gut and catgut. Typical healing ensued, resulting in an excellent stump. The patient was dismissed February 15.

Case No. LVIII. Internal Hemorrhoids—Ligation. R. F. D., æt. 45 years, Dickson, Tenn., entered January 18, with internal

hemorrhoids. Several large nævoid masses presented on defecation, with occasional severe hemorrhage and protrusion, requiring pressure to reduce. Under A. C. E., January 19, the rectum was forcibly dilated, the piles dissected up at the mucocutaneous junction, ligated and excised. The bowels acted on the fourth day without pain or hemorrhage. The patient returned home on January 31.

Case No. LIX. Curettage of the Uterus for Miscarriage. Mrs. J. Y., æt. 19 years, Colorado Springs, Colo., miscarried at three months as the result of a rough railroad trip from the West to this city. The fetus was passed at a hotel in this city and she was brought to the Infirmary January 30. Examination showed the placental mass protruding into the vagina from the os. Under A. C. E. anæsthesia the day of admission, the placenta was removed with placenta forceps and the uterine cavity thoroughly curetted. The cavity was treated with tinct. of iodine and packed with gauze. The patient recovered rapidly and proceeded on her journey February 6.

Case No. LXII. Bilateral Laceration of the Os Uteri—Trachelorrhaphy. Mrs. R. D., æt. 24 years, Goodrich, Tenn., entered February 1 for treatment of a bilateral laceration of the os uteri received during labor with her first child. Under A. C. E. anæsthesia, February 2, the clefts were pared freely, and sutured with No. 1 twenty-day catgut, two on each side. Previous to the uteroplasty, the os was dilated and the cavity of the uterus curetted. Union was perfect and the patient returned home February 13.

(To be continued in August number.)

PUBLIC SANITATION.

B. F. FYKE, M.D., SPRINGFIELD, TENN.

Public sanitation is a theme that is being studied in a manner that it has never been studied before; the campaign for the education of the people in the common principles of sanitation is widespread in its scope, and is producing tremendous results;

people everywhere are becoming more and more interested in sanitation, and the coming of every season witnesses highly beneficial results in the way of prevention. While we are yet in the kindergarten school of sanitation and prevention, we are in the midst of a peculiar combination of forces; there has never been a time in the history of medicine when there was such a universal concert of action on the part of the medical profession to stamp out all contagious diseases by one possible process, and that by *sanitation*.

The progress in sanitation made by both the cities and the rural districts in the last twenty years has been wonderful, but the work has been very much handicapped at times and places by an almost unavoidable combination of difficulties. One of these difficulties was the result of not having money with which to do that which was needed to be done; another one was the lack of coöperation on the part of the laity and some public officials. Success can not result from any great undertaking that is not supported by money and backed by public sentiment. Any great departure from a custom is regarded by the laity as unreasonable and looked upon with suspicion, and time is necessary to teach the people to think otherwise.

When we begin to study general sanitation, there are several problems for solution; our cities have a water supply and sewerage system that are looked after by the city officials, and the problem of water and sewerage does not concern the average citizen; the disposition of garbage is looked after by the city, and this proposition does not worry him, either. All cities have a well organized City Board of Health, and the private citizen is well protected from epidemics of any and all contagious diseases, and if necessary, all exposed families are put in quarantine in order to suppress the epidemic; all property owners are required to keep their premises cleaned up and in a condition that they will not be a menace to his neighbor or the community in which he lives. In the best regulated cities, now, all food is required to be examined before it is offered to the public for sale, and if it does not come up to the standard, it is condemned, and especially is this true of milk and fresh meats. When we go into the

rural districts there is another problem for solution; if the farmer wants water, he must make his own provisions, and get it in any way he can, by either digging a well or cistern, or locating near a spring, and the character of his water supply depends altogether on his own personal ideas, knowledge and judgment, and it is with him to protect his water supply. He can have it pure or impure, wholesome or unwholesome; he must take care of his own garbage and other refuse matter, and oftentimes this is not done in a manner that is the best and safest for himself and his neighbors; he is very much inclined to dispose of all animals dying on his farm by depositing them in a sinkhole or in a gully, then cover them with a light covering of dirt and leaves, making them an easy prey to all other flesh-eating birds or animals, and thereby spreading a contagious disease all over the country. The farmer is not altogether to blame for his conduct in this matter; possibly he has never had any instruction in farm sanitation; but the departments of agriculture, both National and State, are doing good work in this line now, and all farmers are aware that quite a number of diseases incident to their stock and cattle are contagious, and they are willing to employ any remedy by which they can protect their property. Therefore, all animals dying on the farm are either buried or burned, the last method being much the safer and better plan to follow.

Many other plans are being put into use now to remove the otherwise stumbling blocks in sanitation and prevention. Anti-tuberculosis and Civic Improvement and Public Health Leagues are being organized all over the country, and Sociologic Congresses are held in many cities. Public lectures are given to lay audiences, and all school children are taught the principles of sanitation and hygiene. The columns of city and country-town newspapers are offered for the publication of information on the subject and sending it into the homes of many that are not reached in either of the ways just mentioned.

It is a well-known fact that progress in one line of work facilitates advancement in other line of our endeavors—like begets like. There has never been a time, and I suppose there never will be either, when any aggressive movement was not strenuously

opposed by somebody; what one emphasizes and regards of much importance, another is disposed to attach but little value to and regard it as of no importance. The public is too much inclined to place a commercial value on any suggestion in the way of public health. I refer to the people as citizens. Look around you and consider the negro as a disease carrier; look at his habits; they are such as to make him susceptible of every contagious disease. He is poor, filthy, unsanitary in his habits and very hard to teach the principles of cleanliness; he is prone to contract all respiratory diseases, and his migratory habits make him a very dangerous person to occupy rooms close to those of our white people. Go to their homes in their congested quarters and see how they live, where they sleep, and then go home and ponder over your responsibility to them as a people and your families as the one on whom they depend for work. If they are your washerwoman, your clothes are carried into their dirty rooms, washed by dirty women and sometimes by a tuberculosis infected man, as I saw a few days ago. You employ their girls as housegirls, and they go into your parlors, sitting rooms, kitchen and sleeping rooms, and you permit them to nurse your children, go out into the streets and come in contact with other negro girls, and each child is kissed by any and all kinds of children; yet it is custom, and when reminded of it by the medical profession, the laity will say, nonsense; my mother allowed negro girls to nurse me, and I have seen other children kissed by negro girls and women, and I am still living, and I do not think I am better than my children, so I shall pay no attention to the suggestions.

If you wish to make a comparison of the commercial value placed on the opinion of the medical profession in regard to public health, look at the difference in maintaining quarantine in an epidemic of either typhoid fever, scarlet fever or pneumonia, and one of yellow fever, smallpox or cholera, or several cases of tuberculosis in the same neighborhood; there is a self-satisfied expression on the part of the people that they know just what to do, when to do it; an outbreak of either yellow fever, cholera, or spinal meningitis, demoralizes all commerce, because death and sorrow is left in its path, and it behooves everybody to assist in

checking the epidemic. It appears suddenly, travels fast, and is no respecter of persons.

Prior to the discovery of vaccination for the prevention of smallpox, it is estimated that the annual death rate from smallpox alone was 100,000; now, a death is the exception and not the rule from a case of smallpox; but, with the long experience with vaccination as a means of preventing smallpox, we still find people who deny the efficacy of the remedy, and it is necessary sometimes to resort to compulsory vaccination to stamp out an epidemic of the disease; and it is as difficult of explanation why a certain class of our citizens will aid in concealing cases of smallpox, and never seem to be satisfied until there is a widespread area of people affected.

What is true of smallpox is also true of scarlet fever in many sections of the country. It is lamentable to think that there are doctors that still tell the people that there is a difference in scarlet fever and scarlatina—that scarlatina is a milder form of scarlet fever and there is no danger in it. It is the opposition of the ignorant and uninformed that is so hard to overcome and remove with evidence, and it is hard for me to understand why some of our otherwise educated people will accept the opinion of an irregular physician or of an ignorant woman in the place of that from our best physicians, County and State Boards of Health.

But let us compare the criticism and opposition in the use of diphtheria antitoxin and see how rapidly it subsided. Even the few deaths that were attributed to its use did not depreciate its merits as a means of cure and also of prevention, and today it stands as the remedy par excellence in treating diphtheria, and why? Because what is done for diphtheria must be done quickly, and nobody is willing to try the remedies of the "old granny" any more.

Some of us are old enough to remember when Memphis, Tenn., was in the grasp of a terrible epidemic of yellow fever, and when Havana, Cuba, was a veritable hotbed of yellow fever, and was always dreaded by the United State, because it lay almost at its doors. Look back and see what has been done for both of these places and how it was done; both places were cleaned up, the

water supply improved and the sewerage system improved and extended. That was good, and is as true today as it was then, and is as applicable to the homes, both in the city and country alike. It costs human life to prove the cause of yellow fever and the way it is conveyed. After these facts were clearly proven, the remedy was found to be very simple: guard against the bites of the night-flying mosquito.

It took a great deal of time, and cost a large sum of money to learn how to avoid and cure malarial fever. Now contrast the difference in the way the two opinions are received by both the medical profession and the laity. In the malarial and yellow fever sections of the country it is not hard to get the people to respect the opinions of the medical profession and carry out the instructions for the prevention of either or both, but when we meet the doctors that do not see or have to treat either of these diseases, they are oftentimes rather skeptical about the theory of cause and prevention.

Why should there be an epidemic of typhoid fever, either in the rural districts or small towns, now? The cause of typhoid fever and the means of infection are too well known now to admit of any excuse, and it is almost a reflection on the ability of the attending physician to have more than one case in a family, at a time, unless more than one was infected at the same time and from the same source, as by drinking water from an infected well or spring.

Typhoid fever has been prevalent so long, and no teaching having been given as to its being infectious, it is hard for the laity and some of the doctors to accept the instructions that are now given for the management of cases of typhoid fever. Families hate to abandon the use of a spring or well that has been in use for two or three generations, and with a little encouragement from the "old family physician" that does not believe in the "bug" theory, it is almost impossible to get them to abandon the use of the water from this source. And the question of guarding against the common housefly is nearly as great a proposition; it is too much to accept that water can be infected and milk cans then washed in it will infect those who drink it, or that flies lighting

on the discharges from typhoid fever cases, can, or will carry the germ to other people. There is a great work before the medical profession in this line of work, and no doctor is excusable that will yield to the least disregard to respecting the means of preventing typhoid fever, and all doctors should be very clear and thorough in giving rules to be observed in the management of cases of typhoid fever, and I suppose we all know what they are.

Tuberculosis is another infectious disease that has been prevalent a long time and with a high rate of mortality every year; and for a long time it was both taught and believed to be strictly a hereditary disease, and was transmitted or contracted in no other way, and was incurable; but scientific medicine has demonstrated this to be erroneous, and the opposite is taught now—it is contagious and is susceptible of prevention and can be cured. It is in this disease as in many other contagious diseases—prevention is better than treatment, but it is equally as hard to remove the long-made impression that it is transmitted by heredity, because a doctor that lived half a century ago said so, and that makes it positive; but I believe that this idea of the way in which tuberculosis is acquired will be more easily removed from the minds of the people than that of typhoid fever, because the public schools have commenced to teach the manner of infection, and the children will grow up with the impressions indelibly made, and the avoidance of infection will be strictly observed; the publicity that is being given the subject through the newspapers is far-reaching in its results, and the country people are beginning to take notes, and we can see many signs of improvement in the sanitary management of the tuberculosis affected patients; more attention is now given to the negro and his habits than was several years ago, and as time moves on still more will be given to this race. Then we will see a greater reduction in the mortality from tuberculosis.

The work that is being done by the Anti-Tuberculosis and Civic Improvement Leagues is destined to accomplish a great deal of good in stamping out this dreaded disease, and it deserves the approbation of every physician, and we should never let an opportunity pass of reminding the people of the danger in a habit

of promiscuous spitting; the habit of spitting anywhere, everywhere and at any time is filthy, dangerous and very impolite and should never be indulged in by anybody. The use of individual drinking cups is to be recommended and encouraged as one of the safest and sure means of avoiding an exposure to an infection from any contagious disease, and in the public school is the place to have this impression firmly made on the minds of the people. Parents can be reached through the habits of their children, and in the public school is the place to teach the habits that are to be used in after life.

A great deal of agitation is given to the subject of pure food, now, and this is all well and good, and especially is this true of milk. Possibly there is nothing easier to be infected than milk, and the laity are very much in need of instruction as to how milk should be protected. It does not amount to much protection to those who use milk if it is exposed to atmospheric conditions after it is brought from the dairy, even if it was inspected and allowed to be sold, and I am of the opinion that a great deal of complaint that comes up against the quality of milk that is sold is traceable to the homes after it leaves the dairy; but it is in the homes in the country where we owe a great deal of teaching, and especially is this true in the homes where babies are fed on milk. How many of us have seen the milk bucket allowed to stand open out in the dust after it was filled with milk, and all of us have seen flies and babies drinking out of the same cup at the same time. We have seen bottles filled with milk taken from a bucket, given to a baby, and then both would be placed on the floor and the baby would drink from the bottle for a while, then lay it down and allow flies to suck milk from the stopper, or lay it down in the dirt on the floor, and when it got ready to drink, would suck the milk through the dirty nipple on the bottle. How many of us have been called to treat babies with a bowel trouble that could easily be traced to this carelessness on the part of the mother or the nurse? Who is to blame for this? Have we ever given lessons on "How to feed the baby?"

Hookworm disease is another infectious disease that has been prevalent in several of the Southern States for a long time, and

it is only of late that the true nature of the disease has been discovered and recognized as being contagious, and as much credit is due Stiles and Harris for the work they have done in the way of making it plain about hookworm disease as was to Jenner for the discovery for vaccination for preventing smallpox.

The achievements in hygiene, sanitation and public health improvement in all parts of the world in the last twenty years have been very encouraging, and with the financial aid that is being given for the work now, is an incentive for investigators to go on in the great work of searching for the causes, cures and means of preventing diseases. Prevention is the watchword of the medical profession, now, and a hearty coöperation on the part of the laity is the way to get results, and this can not be hoped for without education and training.

Great stress should be laid on the fly as a carrier of disease, and no pains should be spared in teaching the people to see that no flies come in contact with the milk or water that is used for drinking. Every family should be instructed how to destroy all discharges from a patient that is sick with any contagious disease. The use of well and spring water should be discouraged in this day of thick settlements, and the pollution of all streams should be prohibited by law.

The greatest problem before the medical profession is the removal of superstition and prejudice, and we find nearly as much of both in the profession as we do with the laity.

Extracts from Home and Foreign Journals.

SURGICAL

SURGICAL SUGGESTIONS.

The sooner a hollow bone is opened in acute osteomyelitis, the less will be the destruction of bone.

In intestinal obstruction, it is not the operation that is to be feared, but the delay in operation.

When there is disagreement between the pulse and temperature, the pulse must be regarded as of greater importance.

When Kocher's method fails to reduce a recent dislocation of the shoulder, it is usually because the surgeon has proceeded too rapidly. Deliberately is the only way to work quickly.

Traumatic aneurysm, after temporary clamping of the artery, can often be treated by suture if the surgeon goes about it deliberately, when at first impression the case seemed to demand ligation and obliteration of the vessel.

A ligature should not be placed on the carotid too near the bifurcation lest the clot which forms shall not have sufficient surface to which to adhere and become detached and swept to the brain.

If the surgeon desires to discover carcinoma of the cervix in a curable stage, women past middle life must be examined periodically, for to wait until symptoms appear is often to discover the disease too late.

In injuries to the cord, if the tendon reflexes are preserved, even slightly, the surgeon may exclude complete and irremediable severance of the cord; but the total loss of these reflexes during the first few days is not conclusive, as the loss may be transitory.

In performing external esophagotomy, the trachea is the guide for finding the esophagus. It is easy to remember that there is nothing but the esophagus between the trachea and vertebral column.—*American Journal of Surgery.*

ALCOHOL AND SPIRIT OF CAMPHOR AS SURGICAL DRESSINGS.

When I was a medical student in Paris, many years ago, alcohol and water or spirit of camphor and water were habitually used for all wounds as a surgical dressing. They were the favorite and almost the only dressings used by the great surgeon, Nelaton, who in those days was *facile princeps*. Naturally, there was much to deplore as to the results of operations, and, alas, very frequently pyemia, hospital gangrene, and so forth, were daily met with; and on that account many operations were not performed—unless necessity, so to speak, ruled, i. e., the greater chances of death, if no operation was performed.

Since my student days I have seen many new dressings tried, but I am free to confess, so far as my own predilection is concerned, in later years especially, I have not seen any equal to alcohol, or spirit of camphor and water (as a rule one part to three—but the former sometimes pure), with or without an impermeable covering of rubber tissue or oil silk.

Doctor Senn directed attention again to the valuable local use of alcohol—after the late Spanish War—but his practice has not been followed, so far as I know. As for myself, I always use for wounds, bruises, sprains, and so forth, alcohol, or spirit of camphor and water, in preference to any other applications; and I never have had reason to regret it.

On open wounds one or the other is preferable in every particular to bichloride of mercury or any other antiseptic solution. Indeed, I believe it can be shown not only in practice, but experimentally, that they have as great antiseptic power, are far more healing, and have no drawbacks.

Within a few weeks, I have seen an instance of ulceration of large dimensions on the nape of the neck, following a very severe case of carbuncle, in which pure alcohol (ninety-five per cent) first and subsequently spirit of camphor and water worked wonders. Without their use, I am sure skin grafting would have been required, and perhaps not been successful.

I urge strongly that the surgeons who have daily and many opportunities to do so, use alcohol, or spirit of camphor and water

dressings, and verify very soon my statements, and not fail to heed observations and practice simply because they are from a physician. I would add that at times wounds will not heal kindly unless suitable tonics and food are given. As an addendum, I would suggest also to surgeons who still irrigate, that they use alcoholic solutions to wash out the abdominal cavity, after cleansing, in cases of diffuse septic peritonitis from appendicitis.—*Beverley Robinson in The American Journal of Clinical Medicine.*

THE OPERATIVE TREATMENT OF GASTRIC CRISES
IN LOCOMOTOR ATAXIA.

Foerster (*Ther. d. Gegenwart*, 1911, p. 338), tabulates the result in twenty-eight cases where the posterior spinal nerve roots were resected in extreme cases of this condition. These are all the cases reported to date, and most of them are separately and concisely reviewed in this article. All of these cases were those of individuals whose condition was a most pitiable one, in spite of the fact that they had all received the benefit of careful and thorough treatment along approved lines. Of the twenty-eight cases three died as a result of the operation from meningitis or shock. In two cases, the operation resulted in no amelioration. In the remaining twenty-three cases, there was prompt cessation of the crises with marked improvement in the general condition and decided increase in weight. In a number of these cases the relief has been permanent, although in none of them was the period reported on over one and one-half years. In other cases, while there was at first entire relief of the crises, later these returned, although much less frequently and severely than before the operation. When one considers the miserable state of these patients, emaciated to a marked degree and often addicted to morphine, that is to say, poor surgical subjects, the death rate of three in twenty-eight is surprisingly small. Occasionally bladder disturbances and paralysis of the legs followed the operation. This was by no means the rule, and Foerster believes that such happenings should not be expected.

When one considers the desperate and pitiable condition of a

patient with frequent or constant gastric crises, and sees that in the large majority of cases this operative procedure brings complete or marked relief to the sufferer, the conclusion seems inevitable that such patients should be given the chance which this operation procures for them. Further, it is eminently desirable that these cases should be brought to the surgeon before they have lost so much ground as to render them bad surgical subjects.—*New Orleans Medical and Surgical Journal*.

LEG ULCERS, BONE LESIONS ACCOMPANYING CHRONIC.

The old ideas as to the causation and persistence of chronic leg ulcers—constant standing, weakened veins, sedentary life of women, and pelvic troubles incident to their sex—are doubtless applicable, the author remarks, to many cases; but he can not accept them as explaining all. Long-continued ulceration of the leg, whether varicose, specific or undertermined, is often accompanied, he emphasizes, by extensive changes in the underlying bones, often only demonstrable by radiographs. A careful examination and thoughtful interpretation of the latter will permit of differentiating the specific from the non-specific bone lesions.

These underlying lesions of bone are of great importance as regards treatment, as they occur too commonly to be ignored or passed over as occasional. In long-continued ulcerations, the periosteum becomes finally involved. In specific cases the bone process is not by direct extension in the majority of cases, but the bone lesions are an index, as it were, of the probable character of the ulceration of the soft parts. Some cases, however, undoubtedly arise from direct extension of a specific process in the periosteum outward to the soft tissues.

Iodide of potassium will help both kinds, specific or nonspecific, many of these cases having a high-blood pressure. All cases of leg ulcers should have radiographs taken of the underlying bones, and be carefully tested for tabes. Many of them, supposedly varicose on account of accompanying varicose veins, are in reality specific.—*W. Pearce Coues (Boston Medical and Surgical Journal, March 14, 1912)*.

OPERATIVE TREATMENT OF FRACTURES AND DISLOCATIONS.

Dr. William Darrach, of New York, presented this communication, in which he referred to the convention of three years previous, when Dr. Lane said all fractures should be treated by the open method, and declared that the courts would compel surgeons to use this method. Dr. Darrach said he did not agree with Dr. Lane that all or nearly all fractures should be treated by the open method. In the Roosevelt Hospital, he said, they considered that most fractures should be treated by the closed method, but that in certain cases the open method might be employed to advantage. He said there were three classes of these: A, open reduction of recent cases; B, open reduction of old cases; C, cases in which they did not treat to reduce but to correct the deformity resulting from fracture. In the first class, if a satisfactory reduction could not be obtained and maintained by the closed method, the fracture or dislocation should be operated on—no contraindication being present. In transverse fracture of the femur, where the edges engaged, and the patient had a useful and strong limb, why should an operation be performed? Satisfactory reduction might be defined as where increase in the range and degree of deformity by the closed method did not warrant the risk of an operation. "When to operate," Dr. Darrach said, could be answered by saying "After the body has got its breath; after bleeding has stopped, and good, healthy reaction has set in." Too early operation should be avoided, and the body should be spared a second trauma too soon. Also, too light operations should be avoided. Somewhere between the fifth and fifteenth day, he stated, was the best time to operate; and unless a man was able and willing to carry out the exaggerated technique which Dr. Lane advised, he had no right to operate on a fracture. That, he said, was the only way to obviate the deformities that seemed to hover around bone work. No appliance should be left near the bone, if possible to avoid it; in 57 fractures treated by the open method, no appliance was used in 21 of the cases. Plates were used in only 28 per cent, or 16 fractures. Prompt union, Dr. Darrach declared, came a little slowly in fractures that had been opened. When plates

were used, there should be no strain on them, as even a slight pull, if continued, would loosen the screws. In old cases a non-reducing operation should be done, if possible. The technique should be carefully followed out, because with the open method the operations were not always successful.—*Medical Record*.

MEDICAL

ANGINA ABDOMINIS.

Sir Lauder Brunton and W. E. Williams report the case of a patient aged 68 years who suffered from severe pain which came on when he began to walk. In this respect the pain resembled that of angina pectoris, but it differed in its position as it was most severe in the umbilical region. It was at first confined to the umbilical region and was attributed to flatulence, but it gradually increased in severity and extent so that it spread all over the front and back of the chest and caused perspiration to break out over his body. As this pain resembled so closely that of angina pectoris, but occurred in the abdomen, Brunton believed that it might well be termed angina abdominis, and that treatment similar to that of angina pectoris might be useful. He accordingly prescribed trinitrine with the most satisfactory results, as it cut short the abdominal pain in the same way as it would have cut short anginal pain in the chest.—*Medical Record*.

SODIUM NUCLEATE IN THE TREATMENT OF SCARLET FEVER.

Various nuclein preparations have been used in medicine and surgery as therapeutic and prophylactic remedies, ever since Mikulicz showed the powerful action of nucleic acid in calling forth a leucocytosis. It has been shown experimentally that nucleic acid partly protects animals from peritoneal infections, that it seems to have an abortive effect on such infections as erysipelas, and that in general it is of effect in indolent infections where very little reaction is apparent in the infected organism. Writing in *Russkii Vrach* for March 3, 1912, M. G. Molyakoff tells of his

experience with sodium nucleate in the treatment of scarlet fever, his observations being of sufficient interest to deserve a wider circle of readers than the Russian journal affords.

Molyakoff treated altogether 90 cases of scarlet fever, seven of which reached the hospital on the second day of the disease. The most favorable effect of sodium nucleate appeared to have taken place among children of this group. The injection led to a rise in leucocytosis and the disease, or rather the toxemia as marked by fever, seemed to have been quickly aborted, the high temperature dropping to normal in from one to three days. None of these children died. To the second group belonged children that reached the hospital on the third to the sixth day of the disease. No abortive effect of nuclein was noted in this group of cases, yet it seemed to Molyakoff as if the mortality in the 71 members of the group was lower than is usually the case with scarlet fever patients in the Russian provinces. Three children of this group died, two from phlegmonous inflammation of the neck, one from cardiac failure. The third group of patients comprised those who reached the hospital late in the disease; there were few of them, and no effect, favorable or unfavorable, was noted from the injections of sodium nucleate.

Molyakoff has also tried similar injections in a few cases of typhoid fever and of acute articular rheumatism. No effect was noted in the first condition, while in rheumatism the injections seemed to have exercised some favorable influence and especially had an analgesic effect on the joint pains. Molyakoff used a solution of sodium nucleate in 30 to 50 c.c. of distilled water, using 0.1 gram for each year of the child's age. The solution was sterilized by boiling for five minutes. No untoward effects, beyond occasional headaches, were noted.—*Medical Record*.

USE OF ABSORBENT COTTON TO ASSIST EXPULSION OF FOREIGN BODY FROM THE STOMACH.

Halluin (*Societe sc. Medicale de Lille*) reports the following case: Paul l'Er., five years old, presented himself at the Hospital Saint-Antoine, on June 8, 1911. X-ray showed that he had a for-

eign metallic body in the region of the stomach. Two pieces of money were against each other and gave a unique image.

He asked that the child be brought back in two days. The second examination (June 10) showed that the pieces had not moved. He thought that absorbent cotton may be efficacious in removal of the foreign bodies. In order to be able to follow the course of the cotton he had it saturated with bismuth subcarbonate. He had it made into small balls so that the child could swallow it. The child not having had anything to eat since 10 a. m., swallowed these pieces of cotton with pleasure at 4 p. m. The bismuth cotton upon reaching the stomach masked the shadow of the sous. There was no doubt as to the situation of the foreign bodies.

The next day (June 11) at 10 a. m., about eighteen hours after the ingestion of the bismuth cotton, he noticed the formation of a large fecal bolus in the rectum and the bismuth began to show; the bismuth could be seen at the cecum and beginning of the descending colon, the shadow of the two pieces of money appeared clearly at the bottom of the cecum. They had cleared the pyloric barrier but they came behind the mass of bismuth cotton.

About noon the child had a copious stool; the next day (June 12) he expelled the foreign bodies, as the mother specifically stated, without a particle of fecal matter.

This observation show that the ingestion of the cotton clearly facilitated the expulsion of the coins arrested several days in the stomach. But the cotton did not envelope the foreign bodies.

These phenomena are produced perhaps in the case of foreign bodies without rough edges; it would be very interesting to verify by X-rays the correctness of this hypothesis and the means used by the author render this possible.—*La Tribune Medieale*.

PINEAPPLE JUICE IN ANOREXIA.

The author administered fresh pineapple juice to 150 cases in which anorexia was a symptom, including patients with simple anemia, convalescents from malaria, nephritis, pneumonia, typhoid fever, acute and chronic gastritis, and pulmonary tubercu-

losis. In chronic diseases of the stomach in general, especially alcoholic cases, the juice was productive of considerable benefit. In gastric and duodenal ulcer, however, it was not well borne. In nephritis the juice proved useful after the acute attack had passed off, and in tuberculosis cases with anorexia it was also of assistance. In anorexia, following attacks of acute hepatitis, hepatic colic, and acute cholecystitis, as well as in chronic liver and gall bladder cases, the juice materially improved the appetite. In the chronic cases the feces, previously scanty, containing much macroscopic undigested food and having a light color, were considerably altered and improved; upon omitting the juice temporarily they returned to their former condition. In a number of neurotic patients seemingly unable to eat, improvements after administration of the juice was quite apparent, though mention had not been made as to the probable effect expected from the remedy.—*Monthly Cyclopaedia and Medical Bulletin.*

DIABETES AND THE DUCTLESS GLANDS.

After reviewing from the theoretical standpoint the relations existing between the internal secretory glands and glycosuria, the author calls attention to the fact that there is a tendency at the present time to revert to the doctrine that overproduction of sugar is the main cause of diabetes, and to abandon the theory that diminished consumption by the tissues is the essential element. This view is now held by a number of eminent observers, including von Noorden, who consider that the hyperglycemia and consequent glycosuria are due to an excessive output of sugar by the liver, and that this may arise from excessive stimulation or impaired inhibition. The stimulus to the liver may come from an excess of carbohydrate food, as in alimentary glycosuria; from an increased call by the tissues, from hyperfunction of the suprarenals, etc., or from the central nervous system through the medium of the chromaffine system. Impaired inhibition may arise from suppression or impairment of the functions of the pancreas, or from interference with the controlling of the thyroid or hypophysis on that organ. In some cases also there is probably a primary anomaly of the liver cells themselves.

The views at present held with regard to the interaction of the ductless glands and their part in the production of diabetes are to some extent theoretical, and this is particularly so as regards the chromaffine system, but they correlate in a much more satisfactory manner than has previously been possible the experimental data that have accumulated as to the effects of these organs on carbohydrate metabolism, and they bring into line the known facts in the etiology of diabetes. Whether subsequent observation confirms, or in part disproves, these theories, there can be no doubt that they open up a wider conception of the possible pathology of glycosuria, and indicate that it is not a sign of one disease, but a symptom common to several diseases.—*Monthly Cyclopaedia and Medical Bulletin.*

“PTOMAIN POISONING” NOT DUE TO PTOMAINS.

Like many names given hastily or carelessly, this term is now known to be inexact, as generally applied. There are such things as ptomains, and they are poisonous; they are chemical products of decomposition in animal tissue; but the symptoms of poisoning often attributed to the consumption of some article of food are not due to them, but to toxins formed by bacteria. Sometimes these toxins are in the food before it is eaten, but more often the bacteria themselves are there, and it is their activity in the digestive organs that causes the serious or even fatal symptoms usually described as “ptomain” poisoning. This is brought out clearly in an article contributed to *The Hospital* (London August 10), by Dr. H. J. Hutchens, Professor of Bacteriology in the University of Durham. He writes:

“The term ptomain poisoning is inexact, because it leads by inference to the assumption that the symptoms are due to ptomains, while, in fact, as will be shown, these substances are not the cause of the disease. The word ptomain was introduced by the Italian toxicologist Selmi, to describe certain chemical substances more or less allied to the vegetable alkaloids which had been found in putrescent meat and decomposing albuminous matter.

"They are found in only very small amounts in decomposing animal matter, and it is only when meat is in so advanced a stage of decomposition as to be totally unfit for human food that they are present at all. Moreover, many of the ptomains are non-poisonous, and the majority of those that act as poisons exert their influence on the nervous system rather than on the alimentary system. . . .

"Food-poisoning is, therefore, the result of the action of the specific toxins of bacteria on persons who consume meat or other food infected with living organisms or their toxins, or both. The non-specific products should also, perhaps, be included, for though the evidence so far available is against the view that they take part in the production of food-poisoning, it can not be stated as a definitely ascertained fact that they never exert any influence. This definition at once excludes from the category of food-poisoning all cases of poisoning following the consumption of food containing arsenic, lead, strychnine, or other well-defined chemical substance, whether administered intentionally for criminal purposes or taken by accident. On the other hand, the generally accepted use of the term does not include such diseases as enteric fever, Malta fever, etc., though these are also the direct result of eating food specifically contaminated with the organisms of those diseases."—*General Practitioner*.

OBSTETRICAL

GYNECOLOGICAL HINTS.

Sepsis in most puerperal cases starts as wound infection at the vulva or lower end of the vagina, and can generally be prevented by moistening the vulva pads with a bichloride solution 1 to 5,000. This should be continued for about five days.

The umbilical cord should not be cut until after it stops pulsating, especially when the labor has been severe. Many infants have been injured by too much violence during resuscitation.

A woman should not be starved after delivery. The more food she is given within reason, the better.

The breasts should never be massaged or pumped, as disregard of this caution may lead to mammary abscess.

In a general way secondary operations on the perineum should not be performed until the end of at least two months. If they are performed earlier the lochia are apt to interfere with union. It is not necessary to stop nursing an infant for more than a few hours following operations on the perineum.

After all operations of the perineum the bowels should be kept freely open.

When possible it is best to operate for laceration of the perineum before the placenta has been delivered. There is less annoyance from bleeding. The best material is chromicized gut No. 3. It cuts less than silkworm but and does not annoy the patient so much. The sutures should not be drawn too tight, for there is always swelling of the parts that will cause strangulation. A very good needle to use is a full curved three-inch Hagedorn.—*International Journal of Surgery*.

PRECOCIOUS PUBERTY AND OVARIAN TUMOR.

Dr. Verebely (*Wiener klin. Wochensh.*, No. 13, 1912) reports the case of a girl, six years old, who up to five years of age had developed normally. Since a year hemorrhages had recurred monthly, and other signs of puberty had appeared. The child was about four inches taller than one of a corresponding age, and the breasts, which were the size of lemons, contained glandular structure. In the axilla as well as the pubic region there was an abundant growth of hair. The labia were thick and pigmented, and the vagina of abnormal size. Examination of the abdomen revealed a nodular tumor of the size of a child's head connected with the left side of the uterus. At the operation a very vascular ovarian sarcoma was found. The uterus was of the size of that of an eighteen or nineteen year old girl, the right ovary being normal. After operation the hemorrhages ceased, the hair fell out, and the breasts receded in development. The only sign of precocious puberty left was the deeper quality of the voice. The author states that such cases are rare, and he has been able to find

only 126 in the literature, in two of which the condition was due to tumor.—*International Journal of Surgery*.

CAUSES DETERMINING THE SEX.

L. Billon says that embryological facts show how the spermatozoid and ovule encounter one another, each charged with a certain quantity of sex. From their union life is born. Physiology shows that the ovule is detached and becomes fecundable at the moment of ovulation, about the epoch of menstruation. The elements brought by spermatozoid and ovule are opposite; the testicle is female, the ovary male. Greater quantity of sex in the ovary gives a male, in the testicle a female. Clinical facts show that whenever an account of sickness, age, war, etc., the male is inferior, boys are born; but the woman may not be superior to the man on account of sickness, amenorrhea, or the premenstrual period, and conception will be feminine. There are two consequences; the child will resemble morally and physically the stronger parent; the second consequence is autoregularization; the number of increases among animals will be proportional to their mortality; there will be always perfect equilibrium. The child will have the vitality of its strongest parent and the sex of its weaker one; the sex of the weaker will be not only spared but fortified. The generator which is stronger at the moment of conception gives sex to the product, and it is the opposite sex.—*Pacific Medical Journal*.

Dr. Hoag reported a case of hæmaturia in a multipara forty years of age, in her fourth pregnancy. At six and a half months she developed without any discomfort, a considerable quantity of blood in the urine. Beyond the presence of blood there was no pain or discomfort of any kind.

The patient was put to bed, irrigations of alum solution used, and rest enjoined for ten days. It had no effect on the bleeding. She went on to full term and was delivered in a perfectly normal way. The hæmorrhage continued for two weeks after the child

was born, and then stopped as suddenly as it had begun. Dr. Hoag thought that it was the result of intra-abdominal pressure, perhaps the rupture of a small blood vessel. The same night there was a little fleshy plug passed in the urine, which was the only thing ever seen, and coincident with this the hæmorrhage stopped and has not since returned.

Dr. Shears said that although the hæmorrhage might be due to toxic conditions, in the present instance there were no signs of a toxemia. Ruling out local papilloma of a ureteritis, he thought that six and a half or seven months was not too early to exert pressure symptoms sufficiently severe to produce hæmorrhage. From a careful examination of the bladder and the absence of stone or other aggravation cause he should be inclined to attribute the bleeding to this cause.—*Pacific Medical Journal*.

PREGNANCY IN DIABETICS.

It frequently happens that the diabetes become aggravated during a pregnancy, or there is a history of mishaps during previous pregnancies, and it may be advisable to bring on a premature delivery at eight and a half months in the interest of both mother and child. Another reason for this is that the fetus in a diabetic woman is liable to grow unusually large. . If it is found to be increasing rapidly in size, this is another argument for the premature delivery. Another reason is that the mother's diabetes seems to affect the fetus especially during the last few weeks, so that the infant has better chances of survival safely sheltered in an incubator than left in the uterus under the influence of the diabetic poison. In two cases reported the induced delivery passed off favorably for the mothers seemed apathetic and breathed with more or more difficulty, becoming cyanotic and dying five and thirty-six hours after birth. The adrenals were abnormally large in both, but otherwise the organs were apparently normal. One child had an unusual development of fat around the viscera, and it weighed over 4,000 gm.—*The American Medical Association Journal*.

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at \$1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

EXOPTHALMIC GOITER AND METHOD OF DIAGNOSIS.

Prof. Samuel E. Earp, in a clinical lecture at the city hospital, Indianapolis, demonstrates an interesting and valuable method of examination in the diagnosis of this condition. He placed a bandage over the eyes in order to demonstrate the different conditions in the same person. Some cases present no symptoms of eye implication, others no enlargement of the thyroid. In others we notice the implication of one eye and the opposite portion of the thyroid enlarged. One or more of the cardinal symptoms may be absent. There is thus opportunity for a problematic opinion, and the nonobservance of the eyes prevents the so-called snap diagnosis. Commencing at the feet in the examination leaves the head for a climax.—E. S. McK.

TREATMENT OF EXOPTHALMIC GOITRE.

In a clinical lecture before the class at the city hospital, Indianapolis, Earp defined the treatment as follows: Rest in bed, an ice bag to relieve the tachycardia, and bromide of sodium for the insomnia. Trional or possibly morphia may be necessary, the latter to be avoided if possible. A capsule containing 2 grains of ergotine and 1-30 grain strychnia will be given three times a day, and five grain doses of bromide of quinine will be given four times a day. Iron and arsenic are uncalled for unless there is sufficient anemia to require their use. I doubt whether galvanization will render much aid. We shall use digitalis because it has given us good service in the past, although there are some who

will question its utility. The serum treatment advocated by Peebe and Rogers has some followers, but its benefit seems to be limited to acute cases. I have known a number of cases which have been benefited by the X-ray, and sometimes it is necessary to resort to surgical interference.—E. S. McK.

NEVER TOLD TALES.

A dreadfully interesting, a dreadfully true and a dreadfully, dreadful book. It is true, as the author, Wm. J. Robinson, M. D., New York says, "that there are those who will think it were better had these tales never been told. But," he adds, "some old maids are shocked because babies are born naked." Whatever the opinion of the prudes on the sad stories related by Dr. Robinson of sexual sins, no one will deny that a good taste is left after reading the last table, that beautiful story of Prof. Beaumont. Truth is indeed stranger than fiction, and the deep tragedy of these tales strike at the very roots of our civilization. The author has seen young and blooming girls converted into pitiful and barren wrecks within a few months after their marriage. He has seen households made desolate and children orphaned by the mother being carried off to a premature grave; he has seen young mothers reduced within a few years to wornout hags by incessant child-bearing; he has seen children born into the world, puny, crippled, blind and noseless; he has seen many terrible things which can not ever be mentioned here, all brought about, not by the wickedness, but by the ignorance, of men and women entering the marriage relations; all of which could have been prevented if the tales I am telling now had been told before. What a sentence! As true as Scripture, the composition that of Macauley. If you doubt that the author is pure in his motive in telling these tales, read: "I dedicate this humble collection of stories to my dear life companion, who has these many years shared my sorrows and my joys, and my dear children—Victor, Ellen, Frederick and Herbert."—E. S. McK.

AMERICAN HOSPITAL ASSOCIATION. --

The 14th Annual Meeting of the American Hospital Association will be held in the Hotel Ponchartrain, Detroit, Mich., on Tuesday, Wednesday, Thursday and Friday, September 24, 25, 26, 27, 1912.

PRELIMINARY PROGRAM.

President's Address.—Dr. Henry M. Hurd, Secretary, Board of Trustees, John Hopkins Hospital, Baltimore, Md.

Report of Committee on Construction.—Dr. C. R. Holmes, Trustee, City Hospital, Cincinnati, Ohio.

Report of Committee on Training Nurses.

Report of Committee on Hospital Efficiency, Hospital Finances and Economics of Administration.—Dr. Thomas Howell, Supt. New York Hospital, New York City.

Report on Out-Patient Work.—Dr. Wayne Smith, Supt, City Hospital, St. Louis, Mo.

Report on Hospital Accounting.—J. B. Draper, Esq., Supt. University Hospital, Ann Arbor, Mich.

Report on Medical Organization and Medical Education.—Dr. R. O. Beard, University of Minnesota, Minneapolis, Minn.

Report of Committee on Bureau of Hospital Information and Permanent Secretaryship.—Dr. S. S. Goldwater, Supt. Mt. Sinai Hospital, New York City.

Report of Committee to Memorialize Congress to Place Hospital Instruments on the Free List.—Rev. G. F. Clover, Supt. St. Luke's Hospital, New York City.

Report of Committee on Standard Nomenclature.—Dr. Frederick A. Washburn, Supt. Massachusettes General Hospital, Boston.

Social Service in Massachusetts General Hospital.—Miss Ida M. Cannon, Head Worker Social Service Department, Massachusetts General Hospital, Boston.

"The Economic Features and Feeding of Hospital Employes and Patients."—Dr. H. T. Summersgill, Supt. Post-Graduate Hospital, New York City.

Economy in the Operating Room.—Mr. Asa Bacon, Supt. Presbyterian Hospital, Chicago, Ill.

A Contribution to the Problem of Convalescence.—Dr. Fred. Brush, Supt. Burke Relief Foundation, New York City.

The Use of Salvarsan (606) in Hospitals.—Dr. R. R. Ross, Supt. General Hospital, Buffalo, N. Y.

The Cost of Infectious Diseases.—Prof. James W. Glover, Michigan University, Ann Arbor, Mich.

The Relation of the General and Special Hospitals in the Care of the Insane.—Dr. Charles K. Clarke, Supt. General Hospital, Toronto, Canada.

Nursing Standards and the Supply of Pupil Nurses. — Dr. Frederick A. Washburn, Administrator Massachusetts General Hospital, Boston.

The Grading of Nurses.—Mrs. E. G. Fournier, Supt. Minnesota Sanitarium, Gravenhurst, Ont., Canada.

Hospitals and their Duty in Relation to the Prevention of Disease.—Dr. Charles P. Emerson, Medical Department, University of Indiana, Indianapolis, Ind.

Subject to be Announced.—Rabbi Franklin, Temple Beth El, Detroit, Mich.

Subject to be Announced.—Mr. J. R. Coddington, Supt. Polyclinic Hospital, Philadelphia, Pa.

The Hospital Laundry.—Dr. Winford H. Smith, Supt. John Hopkins Hospital, Baltimore, Md.

Hospital Organization with Special Reference to that of the Detroit General.—Dr. W. F. Metcalf, Detroit, Mich.

The Question Drawer.—Dr. Alice Seabrook, Supt. Woman's Hospital, Philadelphia, Pa.

Round Table Conference for Workers in Smaller Hospitals.—Miss Louise Brent, Supt. Hospital for Sick Children, Toronto, Canada, and Miss Amy Armour, Supt. New Rochelle Hospital, New Rochelle, N. Y.

Non-Commercial Exhibit of Hospital Appliances.—Miss Charlotte S. Aikens, of Detroit.

There will be a Trustees' Session presided over by J. L. Hudson, Esq., Chairman, Board of Trustees, Harper Hospital, Detroit, Mich.

Other interesting papers will be presented, the titles of which will appear in the permanent program.

J. N. E. BROWN, M.B., Secretary.

90 Charles Street, East, Toronto, Canada.

Detroit General Hospital, Detroit.

The Cincinnati Academy of Medicine, at its meeting of March 22, adjourned the regular program and turned the meeting into a memorial meeting in honor of Dr. T. A. Reamy. First came the report of the Committee on Resolutions, a beautiful tribute, prepared by Drs. E. W. Mitchell, Allan Ramsey and John M. Withrow. "Dr. Reamy as a Colleague," was the title of an address by Dr. P. S. Conner. He recited his connection with Dr. Reamy in the Medical College of Ohio since 1871. His address closed with the following sentence: "Personally it gives me the greatest pleasure to testify to his value as a colleague in the Medical College of Ohio, still more to his value as a physician, and above all to his value as a man." Dr. Wm. H. Wenning spoke of Dr. Reamy as a member of the Academy. Dr. Wenning had entered the Academy with Dr. Reamy, and had served with him and after him in the capacity of secretary and president. Dr. John M. Withrow spoke of Dr. Reamy as a gynecologist, and having served a time as his assistant. He spoke *ex cathedra*, and did not stint in his praise. Dr. Withrow also said: "The Academy of Medicine never did a wiser thing than when it gave that most notable dinner on the occasion of his seventieth birthday. It was a halo about his declining years that gave the grand old man unspeakable joy. It is the brightest, most human chapter in the chronicles of the good old Academy. How much better the laurels upon the brow than the immortelles upon the tomb." Dr. Louis Schwab spoke of Dr. Reamy as a consultant, his skill, tact, kind, patient, forbearing, forgiving. Dr. Julia W. Carpenter, the first woman member of the Academy, paid a

touching tribute to Dr. Reamy from the woman physicians. Dr. N. P. Dandridge and Dr. Geo. B. Orr spoke, and the Academy adjourned. The attendance was large, especially of those men who were old enough to know Dr. Reamy in his prime.—E. S. McK.

OBSTETRICAL CHARTS IN COLORS.

Ten full plates 12x9 illustrating and briefly describing the following obstetrical positions.

1. Diameters of foetal head, pelvic brim and planes of pelvis.
2. Head presentations.
3. Mechanism in vertex presentations.
4. Mechanism in left occipito-anterior presentation.
5. Face presentations.
6. Mechanism in face presentations.
7. Right mento-posterior position.
8. Breech presentations.
9. Mechanism in breech presentations.
10. Transverse positions.

These plates will be sent in book form to any address on receipt of 25c postpaid.

BATTLE & Co., St. Louis, Mo.

On June 6, at Atlantic City, during the meeting of the American Medical Association, and following a symposium on anæsthesia, the National Society of Anæsthetists was organized. Prof. Yandol Henderson, of Yale, Chairman of the Commission on Anæsthesia of the A. M. A., occupying the chair, those assembled for the symposium acting as a committee of the whole, proceeded to organization, and elected the following officers for the year 1912-1913:

President, James T. Gwathmey, of New York; Vice Presidents, Charles K. Teter, of Cleveland; F. H. McMeechan, of Cincinnati; Yandol Henderson, of New Haven. Secretary, William C. Woolsey, 88 Lafayette Ave., Brooklyn. Treasurer, Harold A. Sanders, of Brooklyn.

The constitution and by-laws were ordered to be drawn by the Executive Committee and submitted to the society for its next meeting for adoption. All names submitted for membership, if qualified in the estimation of the Executive Committee, shall be considered as charter members if presented within a period of sixty days and accompanied by the levied dues of three dollars.

The National Society of Anæsthetists in this notice, calls all those who are actively interested in this work to join its ranks and assist in developing the subject of anæsthesia to greater perfection and more uniform safety.

June 10, 1912.

WILLIAM C. WOOLSEY, Secretary.

FEES IN FRANCE.

A young girl, on a visit to her uncle in the neighborhood of Rhiems, France, was caught in some agricultural machinery, having her leg and arm smashed. The uncle in great haste took his niece to his own doctor at Rhiems, who at once removed the leg and arm. When the father arrived from Paris he found her in the doctor's surgery, which she did not leave until well. When the surgeon's bill was sent—650 francs—the father thought it out of his financial position, especially as he had no choice in the selection of a surgeon or opportunity for agreeing on the terms for the operation, declined to pay, asserting that the bill must be paid by the girl's uncle, under whose care she was when the accident happened, and who had called on his own medical attendant to treat the case. The Paris Tribunal, before whom the case was argued, declared that the father must always be held responsible for the fees of a medical man for attendance on a minor child, and ordered him to pay the doctor's fees.—E. S. McK.

ANCIENT INJUSTICE.

Eugene Aram, whose famous case was immortalized by Hood and Bulwer Lytton, as well as Henry Irving, is one which brings to our minds the question whether half of the criminals who

were, according to the criminal code of the eighteenth century condemned to executions by hanging, strangulation or burning, were unjustly condemned. He was a most unlikely murderer, a profound student, a philologist, he seemed the last one to plan and carry out a murder at night with a great display of physical energy and boldness. Confronted many years later by some old bones found in a cave near Knaresborough, England, his defense was a masterpiece. He pointed out that England was an antique burial ground. In many caves there are found bodies which if not prehistoric may well have been that of some hermit or prehistoric occupant of meriaval times. His remarks on cave burial strangely resembles a Hunterian lecture. In fact one of the bones reputed to be that of the parietal bone of the murdered man has proven to be that of a roe deer. Aram might have maintained that the bones were that of an Ipswich man of latter times. —E. S. McK.

INTERNATIONAL ASSOCIATION OF THE MEDICAL PRESS.

This organization, which has had several meetings, mostly in connection with the International Medical Congress, had a recent convention at Rome in connection with the International Congress on Tuberculosis. The Congress voted that its representative at The International Congress of Hygiene, to meet in Washington in September, 1912, be empowered to convoke a meeting of the American Medical Press Association and invite it to become a member of the International Association. Much attention was given at the Rome meeting to the subject of Medical Terminology, which is becoming complex. Latin was urged for the formation of new words and admixture of Latin and Greek condemned. To describe a series of symptoms the name of the author or discovered might be the shortest way of describing them. For surgical operations a word should be found which described the operation or the part on which the operation was performed. In regard to words now current, the Latin term should be added to the National or popular term. It would be easier to assimilate by adding the Latin than by attempting to

break down the established custom. The French and Italian members were inclined to criticise the permanent committee of the International Medical Congress at the Hague for interfering too much with the methods of proceeding each country felt like following. The meetings at Rome were held in the historic Castle Saint Angelo. Dr. Dejac, Vice President, presided, in the place of Dr. Lucas Champonnier detained by illness. Prof. Augusto Tamburini, on behalf of the Italian Medical Press, entertained the Association at a sumptuous luncheon at the Hotel de Russie, and an evening reception was given by Dr. Ascoli at the offices of *Il Policlinico*.—E. S. McK.

The trustees of the American Medicine Gold Medal Award respectfully announce that the Medal for Nineteen Hundred and Twelve has been conferred upon Doctor William C. Gorgas, Ancon, Panama, as the American physician who in their judgment has performed the most conspicuous and noteworthy service in the domain of medicine during the past year.

WILLIAM J. ROBINSON,
CLAUDE L. WHEELER,
E. EDWIN LEWIS,
Trustees.

OFFICERS OF A. M. A.

The following officers were elected:

President, John A. Witherspoon, Nashville, Tenn., First Vice President, Dr. Philander A. Harris, Paterson, N. J.; Second Vice President, Dr. John L. Heffron, Syracuse; Third Vice President, Dr. H. H. McClanahan, Omaha; Fourth Vice President, Dr. Walt P. Conaway, Atlantic City; Secretary, Dr. Alexander R. Craig, Chicago; Treasurer, Dr. William Allen Pusey, Chicago; trustees, Dr. M. L. Harris, Chicago; Dr. C. A. Dougherty, South Bend, and Dr. T. W. Councilman, Boston. Members of the Judicial Council: Dr. George W. Guthrie, Wilkesbarre; member of Council on Health and Public Instruction, Dr. Walter B. Cannon, Boston; members of Council on Medical Education, Dr. James W. Holland, Philadelphia, and Dr. W. D. Haggard, Nashville.

Reviews and Book Notices

The Care of the Skin and Hair—By William Allen Pusey, A.M., M.D., Professor of Dermatology in the University of Chicago. New York and London; D. Appleton & Co., 1912.

The author's reputation as one of the leading dermatologists in the United States guarantees the scientific character of this unpretentious little book. The author claims that he has in this volume presented a work on the hygiene of the skin and not a guide for the self-treatment of the diseases of that important part. We have found the brochure practical, clear and well arranged. The following table of contents afford an idea of its scope: Chapter I, The Structure of the Skin. Chapter II, The Nutrition and Function of the Skin. Chapter III, The Care of the General Health as it Especially Relates to the Skin. Chapter IV, The Care of the General Health; Diet and Digestion. Chapter V, The Local Care of the Skin; Water and Bathing. Chapter VI, The Local Care of the Skin. Chapter VII, The Local Care of the Skin; Chapter VIII, Inflammation of the Skin. Chapter IX, Disorders of the Face. Chapter X, Certain Defects of the Skin. Chapter XI, The Hair. Chapter XII, The Hair (Continued).

Laboratory Methods, with Special Reference to the Needs of the General Practitioner.—By B. G. R. Williams, M.D., member of the Illinois Medical Society, Assisted by E. G. C. Williams, M.D., Formerly Pathologist for Northern Michigan Hospital for the Insane, Tracy City, Michigan, with an Introduction by Victor C. Vaughan, M.D., LL.D., Professor of Hygiene and Physiological Chemistry, and Dean of the Department of Medicine and Surgery, University of Michigan, Ann Arbor, Mich. Illustrated with Forty-three Engraving. St. Louis. C. V. Mosby Co., 1912.

We take great pleasure in recommending this work as one of the most useful and practical manuals the general practitioner can have. The objects of the authors was to prepare a reference book which would enable physicians to make examinations and chemical tests in everyday practice in the absence of extensive ap-

paratus and the usual fittings of the more elaborate modern chemical laboratories. They have not attempted in this work to set forth every investigation, but comparatively simple cases that are usually sent to cities for expert examination that can be made at home. Such a guide is of very great importance to the general practitioner, as by following the lines laid down in this book he will be enabled to work out for himself the findings so necessary in diagnosing a great many diseased processes the diagnosis of which depends so materially upon chemical and microscopical examinations.

Surgical Clinics of John B. Murphy, M.D.—At Mercy Hospital, Chicago. Vol. 1, No. 1. Octavo of 174 pages, illustrated. Philadelphia and London. W. B. Saunders Co., 1912. Published Bi-monthly. Price per year, paper, \$8.00. Cloth, \$12.00. W. B. Saunders Co., Philadelphia, London.

We are indebted to the accommodating publishers for a copy, No. 3, of *The Surgical Clinics* of Dr. John B. Murphy. In our notices of the two preceding numbers of this valuable serial publication we commented favorably upon the usefulness of the clinics in printed form as affording physicians who can not attend in person an opportunity to gain some knowledge of the advanced ideas and improved methods of this great surgeon. The present number is especially interesting. A large number of clear skiagrams are introduced, serving to show the results of work done in bone surgery. Regarding these illustrations one is tempted to regard the wonderful results accomplished as phenomenal. The author's success at bone grafting alone would have been sufficient to have rendered his name famous as a surgeon. Besides the lectures upon bone surgery, there are interesting cases of Tuberculosis of the Intestines, Cystic Goiter, Double Cervical Rib, Tumor (Hypernephroma) of the Kidney, Cholelithiasis, Typhoid Spine (Extradural Hemorrhage from Trauma, etc. Certainly a collection of extremely interesting cases, rendered doubly so by the way in which they have been handled by this master surgeon. Of great interest and practical use to the physician should be the diagnostic methods which Dr. Murphy constantly uses in his practice. The

profession is under lasting obligations to the publishers for having put in course of publication these clinics, and everyone should avail himself of the opportunity afforded him by this serial. Personally we always eagerly look forward to the appearance of each issue.

Publisher's Department

"Robinson's Lime Juice and Pepsin" is an excellent remedy in the gastric derangements particularly prevalent at this season. It is superior as a digestive agent to many other similar goods. (See page 8, this issue.)

AN UNEXCELLED COMBINATION.

Two parts of Dioivburnia to one part of Neurosine is par excellence in Hysteria, Eclampsia, Melancholia, Female Neurosis, Uterine Congestion, Ovarian Neuralgias, an Efficient Diuretic, Asthma Sexualis, Uterine Irritability, Lumbago, Migraine, Menopause, Menstrual Colic, Anemic Nervousness, Nervous Prostration, Reflex Cough, Delayed Catamenia, Non-Descriptive Cases, Subacute Rheumatism, Relieves all False Pains, Rheumatic, Sciatic Pains, Neurasthenia from Uterine Diseases.

Professor Davenport, in his admirable work on the Diseases of Woman, Dr. L. G. Boyd, Tunnelton, Ind., reviewing, adds:

How can we prevent dysmenorrhea? It can be done by keeping the patient under morphine, but this is a barbarous solution of an important problem. It in fact does not solve it. Morphine is inadmissible and improper in these cases. It produces derangement of the secretions and tends to establish a drug habit that will make life a burden. I have long employed a remedy that not only relieves the pain, but produces no habit and is not dangerous. I refer to Dioivburnia. It is a most valuable uterine tonic, antispasmodic and anodyne of exceptional worth. I rely upon

this remedy to prevent dysmenorrhea, which, as Professor Davenport truly says is seen in almost all, if not in all, women. I have my patients who suffer with dysmenorrhea to take Dioviurnia, beginning two days before menstruation is due and persist in it until the period has passed. I give it in doses of one or two teaspoonfuls every three hours throughout this time. When this direction is followed I have found that my patients go through the period without pain. The adoption of this treatment I may say also, has brought me many grateful compliments.

Where the patient is very nervous, having the tendency to hysteria, neuroses or uterine congestion, I administer Neurosine one part, in combination with two parts of Dioviurnia, which always gives relief.

BY R. GRAHAM HEREFORD, M.D.

A fifteen months old bottle-fed baby presenting the following:

Temp. 103°F., bowels had been moving twelve to fifteen times during the twenty-four hours for two days. Stools greenish in color, streaked with blood and very offensive; vomiting incessant.

Diagnosis: Cholera Infantum. Treatment: 1-10 grain Calomel and Soda Bicarb every half hour until character of actions changed. Injected high into bowel every six hours a solution composed of Glyco-Thymoline, two ounces to a pint of hot water.

Twenty-four hours later, temperature normal, child much brighter. The ordered the following prescription:

R Liquor Bismuth, U. S. P.

Glyco-Thymoline aa $\bar{\text{5}}$ 1-1.

M-sig. Teaspoonful every three hours.

Child entirely well on fourth day.

SPECIAL OFFER.

To demonstrate the value of Glyco-Thymoline in summer complaints a pound bottle will be sent upon application to any physician, free of all cost, carriage charges prepaid.

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NASHVILLE JOURNAL — OF — MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

Vol. CVI.

AUGUST, 1912.

No. 8.

Original Communications

ANNUAL REPORT OF SURGICAL OPERATIONS AT
THE PRIVATE INFIRMARY OF DRS. CHARLES S.
AND SAMUEL S. BRIGGS DURING ITS TWENTY-
FIRST SEASON, FROM SEPTEMBER 10, 1911, TO
AUGUST 1, 1912.

REPORTED BY W. T. BRIGGS, M.D., NASHVILLE, TENN.

(Concluded from the July number.)

Case No. LXVI. Appendical Abscess—Incision and Drainage.
J. W. T., æt. 23 years, resident of the city, admitted February 11.
The patient had been suffering from a severe attack of suppurative appendicitis for several days, with rapid pulse, high temperature, pain and the formation of a large globular mass in the region of the appendix. The abscess was evidently well walled off. Under A. C. E. anæsthesia, the day of admission, an incision four inches in length was made directly over the most prominent part of the tumor, the abscess cavity opened, and a large quantity of pus evacuated. Brief search failing to locate the appendix, further efforts were not prosecuted from fear of opening into the general peritoneum. A large tubular drain was passed to the bottom of the abscess sac and sterile gauze packed around it. The tube was removed on the third day, and subsequent dressing consisted of loose packing with gauze. The cavity slowly filled up and healed, and the patient was dismissed March 10.

Case No. LXIX. Double Urethra and Imperfect Prepuce. F. D., æt. 12, Springfield, Tenn., admitted February 22, for treatment of difficult micturition due to congenital stricture of the urethra at the meatus. The meatus was marked by a depression. In this pocket presented two minute orifices, one above the other. A small eye probe passed into the upper an inch and a half, where the canal terminated. Through the lower the probe passed into the urethra proper. Under chloroform, February 23, the two openings were converted into one with a canaliculus knife and the passage freely opened. A number 12 sound, American scale, was then readily passed into the bladder. The prepuce, which was defective inferiorly, was truncated and sutured. Dilatation was practiced every day and the patient was dismissed March 6.

Case No. LXXII. Partial Laceration of the Perineum—Perineorrhaphy. Mrs. J. H. H., æt. 38, Eastland, Tenn., was admitted February 28 for treatment of old partial laceration of the perineum. The patient was in a nervous state of health due to this lesion, and there was present both cystocele and rectocele. Under A. C. E., February 29, the perineum was repaired after the method of Dudley, silkworm gut being used for the deep sutures and catgut for the vaginal. Healing was typical and the patient was dismissed April 2.

Case No. LXXIV. Epithelioma of the Lower Lip—Excision. A. D., æt. 79 years, Hartsville, Tenn., entered February 29 for removal of epithelial carcinoma of the lower lip. The ulcer was placed at the junction of the middle with the outer third of the lip; was about half an inch in diameter, hard, and with elevated edges, and bled readily on touch. There was no glandular involvement. Under novocain infiltration, the growth was excised by V-shaped incision, and the edges of the wound secured with silkworm gut sutures. The sutures were removed on the sixth day and union was found perfect. The patient was dismissed on the twelfth day with hardly a sign of disfigurement.

Case No. LXXVI. Cirroid Aneurysm of the Scalp—Multiple Ligation of Arteries. J. W. J., æt. 58 yrs., Nolensville, Tenn., entered Feb. 29, for treatment of a pulsating tumor of the scalp, sit-

uated just behind the left ear. The enlargement had been noticed several months before admission, and was rapidly increasing in size. The tumor was about 4 in. in diameter, and at its most prominent part about an inch and a half in thickness. The mass pulsed visibly, but there was very little bruit. March 6, under first novocain infiltration, then A. C. E. anæsthesia, ligatures were applied to the occipital artery near its origin, to the posterior auricular and to the posterior branch of the temporal. Pulsation was diminished and the volume of the tumor reduced. The wounds healed rapidly. Two weeks later other arteries were ligated at the periphery of the tumor and the swelling was further reduced, but pulsation was still faintly seen. The patient was dismissed March 30 with instructions to return in three months for more radical treatment by dissecting out the sac.

Case No. LXXVIII. Volksman's Operation for Hydrocele. J. D. S., æt. 45 years, Guthrie, Ky., entered March 2 for treatment of hydrocele of the tunica vaginalis testis. The scrotal enlargement was of several years standing and presented the characteristic features of hydrocele. March 3, under A. C. E., the cavity of the tunica vaginalis was opened by a four-inch vertical incision, about six ounces of straw-colored fluid evacuated, the tunica vaginalis joined to the scrotal integument with continuous catgut suture and the two sides brought together by a deep suture of silkworm gut. Recovery was satisfactory and the patient returned home March 14.

Case No. LXXX. Removal of Adenoids. J. G., æt. 9 years, Waverly Place, Tenn., was admitted March 2 for removal of adenoids. Under chloroform, the day of admission, the growths were removed with the adenoid curette, and the passages satisfactorily cleared.

Case No. LXXXV. Chronic Appendicitis and Retroversion of the Uterus. Mrs. H. G., æt. 33 years, East Nashville, Tenn., entered March 14. The patient had suffered for several years with chronic appendicitis and retroversion of the uterus. Under A. C. E. anæsthesia, March 15, the peritoneal cavity was opened by six-inch incision in the median line, the appendix delivered and

removed and its stump invaginated. The uterus was in extreme retroversion, and was bound down by strong adhesions, which were broken up with some difficulty. The ovaries were in good condition. Ventrofixation of the uterus was effected by two No. 2 chromotized catgut sutures. The parietal wound was closed in the usual manner. Recovery was uneventful and the patient was dismissed April 9.

Case No. LXXXVI. Intra-Capsular Fracture of the Femur. Mrs. S. G. R., æt. 66 years, East Nashville, Tenn., admitted March 20. The patient had sustained an intra-capsular fracture of the femur from a fall ten days before admission. The cardinal symptoms of such fracture, shortening, eversion of the foot, ill-defined crepitus and inability were present. The X-ray demonstrated the presence of fracture and the extent and character of displacement. The limb was put in Gurdon Buck's extension apparatus with sufficient weight to overcome the shortening and sandbags applied on each side of the limb to prevent lateral displacement. The patient bore the treatment well and was permitted to return home May 18. The subsequent progress of this case will be referred to later on in this report.

Case No. LXXXVII. Exophthalmic Goitre—Thyroidectomy. Miss M. L. E., æt. 26 yrs., city, admitted March 20 for treatment of exophthalmic goitre. The enlargement of the gland was chiefly on the right side and was at the expense of the posterior portion as indicated by dysphagia and hoarseness. The cardinal symptoms of the disease—nervousness, tachycardia, exophthalmos and profuse diaphoresis—were well marked. The patient was placed under treatment preparatory to operation with marked amelioration of all the symptoms. April 7 the line of incision was cocaineized by infiltration, and Kocher's incision made. After making the cutaneous incision, it was found necessary to resort to general anæsthesia with A. C. E., under which the remainder of the operation was done, removing the right half of the gland. The recurrent laryngeal nerve was exposed and drawn aside. The arteries were readily secured. Hemorrhage was small. The pretracheal muscles were not divided but drawn aside. The

wound was closed with continuous suture of very fine silk. Recovery was satisfactory. The patient returned home April 24 completely relieved of all the unfavorable symptoms of the disease.

Case No. XC. Carbuncles of the Back—Incision and Curettage. C. W. A., æt. 52 years, Davidson County, Tennessee, admitted March 21, with large carbuncle. The patient had glycosuria to the extent of $3\frac{1}{2}$ grs. to the ounce. The carbuncle was located in the middle dorsal region below the angle of the left scapula, and was about six inches in diameter. Under infiltration anæsthesia with novocain, the swelling was incised with two intersecting incisions six inches in length, and the flaps dissected up to permit of free curettage. The wound was swabbed out with pure carbolic acid, followed with alcohol, and the cavity packed with gauze. Two weeks later another carbuncle nearly as large as the first appeared on the opposite side and was subjected to the same treatment. A number of furuncles formed at various points during convalescence and were evacuated by incision. Sugar was, by treatment and diet, reduced to $\frac{1}{2}$ gr. to the ounce. The wounds filled up slowly and the patient returned home in about six weeks.

Case No. XCII. Large Sebaceous Cyst—Excision. M. H. B., æt. 49 years, East Nashville, Tenn., entered April 10 for removal of a sebaceous cyst. The tumor was about the size of a hen egg, placed over the right scapula and had been inflamed as the result of pressure of his suspenders. Under infiltration with novocain the tumor was dissected out through a three-inch incision made in the long axis of the growth and the wound closed with continuous catgut suture. The wound healed rapidly without accident.

Case No. XCIV. Necrosis of Portion of Inferior Maxilla. E. T. N. æt. 42 years, Newbern, Tenn., entered April 13 for treatment of dead bone in the left lower maxilla, the sequela of typhoid fever a number of years previous. A fistulous orifice presented on the body of the jaw just above the border near the angle through which a probe was brought in contact with loose, movable bone. Under local anæsthesia, an inch and a half in-

cision was made along the border of the body of the jaw, the sequestrum of detached dead bone, a spiculum as large as the thumb nail, was exposed and lifted out. The exposed portion of the maxilla was curetted and the wound closed with catgut. Satisfactory healing followed and the patient was dismissed April 19.

Case No. XCVI. Acute Suppurative Appendicitis—Appendectomy. E. C., æt. 12 years, Hartsville, Tenn., admitted May 1, with acute appendicitis. Loss of area of hepatic dulness pointed to perforation of the appendix, and operation was done as soon after admission as possible. Both chloroform and A. C. E. were used, beginning with the former. A four-inch incision was made in the right semilunar line, considerable pus evacuated and the appendix delivered and removed. The stump was invaginated with purse-string suture. The parietal wound was closed with through and through silkworm gut sutures tied after serial suture with catgut of the perineum and fascia. The appendix was gangrenous and perforated. Recovery was uneventful and the patient was dismissed May 21.

Case No. XCVIII. Wound of the Ulnar Artery—Ligation. Miss B. W., æt. 23 years, city, entered May 7, with a punctured wound over and leading into the antecubital fossa. The very profuse hemorrhage had been controlled with tourniquet. Under A. C. E. the wound was enlarged upwards by a four-inch incision and the artery exposed. The wound was through one side of the artery, the distal and proximal ends of the vessel being held together with a strand. Both ends were ligated and the artery between completely divided. The fascial coverings were sutured and the cutaneous wound closed with continuous catgut without drainage. The patient was taken home the same day. The wound healed by first intention and the case was dismissed May 17.

Case No. C. Suprapubic Hysterectomy for Uterine Fibroids. Mrs. C. J., æt. 48 years, resident of the city, entered May 20 for treatment of profuse hemorrhage from uterine fibroids. According to history the growths had been present for years, but only since December, 1911, had the hemorrhage incapacitated her. The customary internal medication only partially controlled

the hemorrhage, and at the time of the operation, in spite of prolonged pre-operative treatment, her hemoglobin was down to 40. May 24, under A. C. E., the abdomen was opened by six-inch incision in the median line and the uterus, tubes and ovaries removed. The left ovary was cystic, but the tube was normal in appearance. The right ovary was hard and atrophied while the corresponding tube was distended with a clear watery fluid. The small fibroid extended into the cavity of the uterus, the mucous membrane of which showed the usual degenerative changes. The pelvic peritoneal wound was closed from side to side with a continuous catgut suture and the parietal wound closed in the usual manner. The patient made an uninterrupted recovery and returned home June 10.

Case No. CIII. Chronic Appendicitis—Appendectomy. Miss B. C. L., æt. 20 years, Waverly, Tenn., entered May 21 for treatment of chronic appendicitis. The patient had suffered a number of severe attacks of appendicitis and was never entirely free from pain in the appendical region. Pressure elicited tenderness, and there was constantly present some rigidity of the muscles on the right side. May 24, under A. C. E., the cavity was opened by three-inch incision in the right semilunar line, the appendix delivered, removed, and its stump invaginated. The parietal wound was closed as previously described. The appendix was thickened and its mucosa presented the usual evidences of chronic inflammation. The patient made a perfect recovery and was dismissed June 15.

Case No. CV. Ununited Intracapsular Fracture of Femur—Operation by Fixation of Fragments by Nailing. B. C., æt. 25 years, resident of the city, entered May 20 for treatment of an ununited fracture of the femur from a fall about ten months before admission. The limb was shortened two and one-half inches and the patient was able to walk with difficulty on crutches. The X-ray showed fairly good apposition of the fragments, but almost complete absorption of the neck of the bone. As preliminary treatment, the patient was placed in Buck's extension apparatus for 10 days with the view of rendering the shortening as

little as possible. This succeeded, so that the shortening was reduced to $\frac{1}{2}$ inch. Under A. C. E., June 2, with the limb held in forcible extension, a 4-in. incision was made over the great trochanter and the bone cleared. Guided by an X-ray plate of the fracture a small hole was drilled though the trochanter into the head of the femur and a 20-penny steel wire nail $4\frac{1}{2}$ inches in length driven through one fragment into the other, burying the nail up to its head. The wound was carefully dressed and the limb put in plaster of Paris extending from the foot up to the nipples. After two weeks the patient was permitted to get upon crutches and is at this writing still wearing the splint. The wound has never given any trouble. The nail will be left unless it causes irritation.

Case No. CVII. Enlarged Cervical Glands—Removal. Miss C. H., æt. 26 years, Nashville, Tenn., entered May 14 for removal of large chain of cervical glands extending from the mastoid process to the clavicle. An operation had been performed several years previously on both sides of the neck for a similar condition, and the return of the disease was chiefly on her left side. Under A. C. E., May 16, the cicatrix of the former operation was dissected out so as to expose the growths, and fifteen glands, ranging in size from a hen egg to a filbert, were removed. Some of the growths were closely applied to the carotid sheath, which was exposed for two inches. The wound was carefully closed with subcuticular sutures and the patient was dismissed June 1 with a very pretty scar.

Case No. CIX. Carcinoma of the Cervix—Vaginal Hysterectomy. Mrs. H. T. L., Smith County, Tennessee, entered May 18 for treatment of cancer of the cervix. The patient was 52 years of age and had suffered from a constant bloody discharge, which had persisted for several years after her menopause. Examination disclosed an extensive ulcerated condition of the cervix, which was indurated and bled upon touch. The uterus was freely movable and the neighboring parts were apparently free from involvement. Under A. C. E., May 20, the uterus and appendages were removed by the vaginal route. Rapid recovery followed and the patient was dismissed June 4.

Case No. CXV. Recurrent Appendicitis—Appendectomy. Miss A. C., æt. 23 years, Paris, Tenn., entered June 2 for treatment of recurrent appendicitis from which she had suffered for several months. Some of the attacks had been very severe, from the last of which she had just recovered. The ovaries and tubes had been involved and an investigation of those parts was necessary. Under A. C. E., June 4, the cavity was entered by a four-inch incision in the median line and the ovaries and tube found inflamed, but not so seriously involved as to require removal. The appendix was removed and its stump invaginated. The parietal wound was closed in the customary manner, using clips in place of catgut intervening sutures. The appendix showed inflammation in the presence of adhesions and thickening. The patient made a good recovery and was dismissed July 2.

Case. No. CXVI. Lipoma of the Shoulder—Removal. Mrs. L. C., æt. 42 years, resident of the city, entered June 6 for removal of a growth situated over the left scapula. The tumor was globular in shape, about four inches in diameter, painless and free from tenderness, smooth over its surface and dimpled when grasped. The neoplasm was evidently lipomatous in nature. Under A. C. E. the day of admission, the mass was exposed by six inch incision and readily dissected out. It proved to be a typical fatty tumor. The wound was closed with continuous catgut suture. Rapid healing followed and the patient was dismissed June 12.

Case No. CXX. Adeno-Fibroma of the Mammary Gland—Excision. Mrs. A. G. D., æt. 28 years, Hartsville, Tenn., entered June 18 for removal of a small growth in the left breast of several years duration. The tumor had given no pain until recently, when it commenced to give some trouble, and it was at the time of admission painful and tender to the touch. It was located in the superior external quadrant, hard and movable, and about the size of a walnut. Under A. C. E. the growth was excised through a four-inch incision and the wound closed with continuous catgut suture. The wound healed readily, but had to be opened on the sixth day on account of hemorrhage in the deeper parts of the

wound. This accident delayed recovery somewhat, but the patient made a good recovery and went home in two weeks.

Case No. CXXI. Curettage for Endometritis—Labial Cyst and Vulval Tumor. Mrs. J. B. D., æt. 30 years, resident of the city, entered June 18. Examination showed a severe endometritis with its attendant symptoms and the presence of a cyst of Bartholins gland on the left side and a fibroid tumor on the right side at the introitus. Under A. C. E., the day of admission, the cervix was dilated and the uterine cavity curetted with sharp and dull curettes and packed with gauze. The cyst was dissected out entire and the fibroid removed. Catgut sutures were used to close the wounds. The patient made a good recovery and was dismissed July 1.

Case No. CXXIV. Salivary Calculus and Tumor in the Submaxillary Gland. J. W., æt., Springfield, Tenn., entered June 20 for treatment of a growth in the left submaxillary gland. The patient complained of soreness in the floor of the mouth, which, on examination, showed an ulcer. The probe at this point detected a calculus which, after dilating the orifice, was removed. The calculus was nearly an inch in length and half an inch in thickness. The growth in the gland was removed with part of the submaxillary gland through a two-inch incision under the border of the jaw. Recovery was rapid and the wound closed satisfactorily with but transient loss of saliva.

Case No. CXXV. Varicocele—Excision of Veins. J. L. S., æt. 24 years, Chattanooga, Tenn., admitted June 20 for treatment of large varicocele of the left side. The mass of veins was very large and caused the patient a good deal of uneasiness by reason of the weight and dragging it produced. The testicle of that side was perceptibly smaller than normal. June 21, under A. C. E. anæsthesia, the veins were exposed through a vertical incision, the vas deferens isolated and the veins ligated with strong catgut at an interval of an inch. The stumps of the veins were approximated by tying the respective ligatures together and the wound was closed transversely. A prompt healing followed and the patient was dismissed June 30.

Case No. CXXVI. Nephropexy for Dropped Kidney. Mrs. J. G. C., æt. 32 years, East Nashville, admitted June 15, for treatment of a dislocated kidney and kinking of the ureter. Six weeks before admission, while lifting some heavy article of furniture, the patient experienced a sharp pain in her right side and back, which forced her to go to bed. Examination discovered in the right side a mass somewhat larger than a normal kidney extending from under the liver nearly down to the iliac crest. The swelling was tender and the source of constant pain. The secretion of urine was greatly reduced, two to three ounces at a passage, and from 10 to 15 ounces in the 24 hours. After eight days of preparatory treatment, June 23, under A. C. E., the kidney was exposed through Koenig's incision, and after breaking up with difficulty numerous adhesions, delivered upon the back and palpated. The capsule was divided along the convexity and the kidney partially decorticated. By the passage of a strong catgut suture through the capsule, passing under the lower pole of the kidney and passing around the twelfth rib, where the ends were tied, the kidney was suspended in a sling. A second suture was passed through the cortical substance of the kidney and attached to the edges of the muscles. The wound was closed without drainage. The patient made a good recovery and returned home three weeks after operation.

Case No. CXXX. Compound Fracture of the Ulna. Mrs. J. D. S., æt. 66 years, East Nashville, Tenn., entered July 10 for treatment of compound fracture of the left ulna, received from a fall while walking upon crutches. This patient, whose case was described in Case No. LXXXVI, had nearly recovered from the intracapsular fracture when she sustained this compound fracture. The upper fragment of the ulna protruded through the soft parts about two inches above the wrist. The hip was contused but not refractured. The limb was dressed with every precaution against infection and put in splints. The wound healed without accident, and the patient went home July 31.

Case No. CXXXIII. Enlarged Inguinal Gland—Excision. T. W. P., æt. 28 years, Memphis, Tenn., admitted July 15 for treat-

ment of large bubo in the left inguinal region. The patient had suffered from chancroids, and this infection appeared about three weeks after the appearances of the venereal ulcers. The swelling was as large as a goose egg, hard and tender upon pressure, but there was no fluctuation. Under A. C. E., July 16, the gland was exposed by 4-inch incision parallel with Poupart's ligament and the mass dissected out. The gland broke down before the removal was complete, discharging considerable quantity of pus, necessitating piece meal removal and a thorough curettage of the cavity. The cavity was packed with gauze to fill up by the granulating process. The patient was dismissed August 7.

Case CXXXV. Oesophageal Stricture from Concentrated Lye—Dilatation. F. C., æt. 3½ years, Burksville, Ky., entered July 17 for treatment of stricture of the œsophagus caused by swallowing concentrated lye about three months before admission. The child could swallow liquids with difficulty, but after taking solid food she invariably rejected it after a short time. Examination located the stricture just behind the sternal notch and the passage would only admit at the first effort a number 14 French urethral bougie. Gradually increasing sizes of bougies were passed every other day until number 19 could be used, when the patient's swallowing had improved so much that she was permitted to go home to come back in September for further treatment. At the time of dismissal the patient could swallow solid food without difficulty and it was no longer regurgitated.

THE ORIGIN OF TORTICOLLIS—ILLUSTRATION OF A CASE.

By TOM A. WILLIAMS, M.B., C.M., Edin., Washington, D. C.
(Member Corresp. Socs. de Neurol. and Psychol., Paris. Neurologist to Epiphany Free Dispensary, Etc.)

It is not often that the pathogenesis of a torticollis is so clearly elicited as in the case now reported, although it is true that Janet in "*Les Obsessions et Psychasthenie*" has traced the source of many tics, and has shown how often they are the symbols of former acts of a clearly purposive intent.

Failure to think in terms of function is responsible for the persistent attempt, especially of surgeons, to find a local cause * for such an abnormal movement or attitude as torticollis. When none could be found, a hypothetical neuritis used to be invoked, and division or excision of the spinal-accessory nerve was often resorted to, usually utterly without benefit; although in some cases of hysterical type the enforced rest after the operation and the violent psychical impression abolished the tic of the neck for a time at least.

Naturally, such an operation was in itself quite inefficacious, for it is clear, even after a superficial examination, that not only do the sterno-cleido-mastoid and the trapezius contract, but all the muscles of one side of the neck participate in the torticollis; so that a cutting operation to abolish the movement would demand division either of the cervical plexus or of its roots in at least the first six segments of the spinal cord, as well as of the spinal accessory nerve. But the exceedingly involved explanations demanded to account for a torticollis by a disease of lower neurones need no longer trouble us, for the mechanism of the vast majority of cases is purely psychologic, and the case which follows is a beautifully simple example thereof.

*Though it is true that local irritations are in some cases the provocatives of tics, yet they do not act in a directly reflex manner, but through the medium of the psychics, by setting up a defense reaction much more complex than that of a simple reflex.

It would be gross error to attribute this patient's neuroticism to her loss of weight, atonia, and physical depression in general. It is these, on the other hand, which are secondary to the psychological perturbation she had suffered. The mechanism is somewhat as follows: Shame and grief destroyed appetite and prevented assimilation, worry caused insomnia; hence came malnutrition, with asthenia of the neurones, an intoxicative condition in the wider sense of the word. In this way is produced the muscular hypotonia. Exaggeration of the deep reflexes might be explained as due to a specially great asthenia of the *fortex cerebri*, the Rolandic portion of which inhibits deep reflex response.

CASE OF TORTICOLLIS, CAUSING GRAPHO-SPASM.

Single woman, E. L., aged 31, expert counter in the U. S. A. treasury.

Complaint.—Can not use right arm, for each motion causes the head to turn to the right, "and I am compelled to look right backwards with a most powerful force over which I have no control." It began three months before with a pain behind the right shoulder running round to the right side. She now has pain all the time. She consulted a physician, who called it neuritis, and advised massage. The nurse who was called feared to massage her; so electricity (*sic*) was tried, and did good at first to both the pain and the movements.

She had fallen on this shoulder in August, but it did not trouble her after the first few days.

The movements and pain had been bearable until a month before she saw me, and she had left her work from time to time, on one occasion for three weeks.

Present State.—Appetite good, no indigestion or pain; and the general physical examination showed nothing abnormal except loss of weight, atonia and exaggerated reflexes.

Psychic Examination.—No marked defect of memory, attention, judgment in general matters, nor emotional reactions; but she is much worried about her condition, which she *believes to be a physical malady*. As will appear from the psychoanalysis, there are other worries which she did not at first reveal.

Onset.—She had no unusual worry at the time, she declares, but on account of straightened finances and the delicacy of her mother, she has been anxious for some years. As a result of psychoanalysis, it was ascertained that three months before the tic there had occurred a serious unpleasantness with a comrade in the office, whom she stigmatized as an ignorant, conscienceless woman. The emotional bitterness displayed in the patient's account was an immediate index of the serious pathological significance of this episode. Her attempts at harmony caused no satisfaction, so she declares that she ceased worrying. "I had tried to adjust it, but failed; for she is a married woman older than and above me in the office. She is angered because I don't associate with her. But as she had spoken disparagingly of my mother, I taxed her, only to meet with denial."

She brooded deeply over this episode, and as her work in counting can be performed quite automatically, her thoughts were free all day long to dwell upon the constant unpleasantness of being in the same room as the other woman, who *sits behind her on the right*.

Some three years before she had renounced marriage for the sake of her mother, on account of a love affair which had turned out unfortunately. Her mother, too, had had an unfortunate marital experience, the knowledge of which has tended to strongly depress the patient's mind. But in spite of all this she declares that her home is happy with her mother and sister, for whom she has a strong affection and admiration, and terms "a practical Christian. She has always been most anxious to do her duty and to make good at her work, but she confesses that since the quarrel with her fellow-worker, her thoughts have been preoccupied by the unpleasantness it has caused, in which, however, she believes herself to have the sympathy of many of the other girls. But at work she can not help thinking of the other woman.

Examination of the Origin of the Tic.—It is evident that the girl's thoughts about her enemy cause her head unconsciously to veer and turn towards where she knows her to be. This is the less easy to resist because her attention is partly occupied by the counting of the money which is her duty. As she is anxious to

do this as rapidly and well as possible, mistakes or insufficient work not being condoned, she is the less able to resist the motor response to her underlying thought, which is essentially a desire for an understanding with the other woman and a reconstitution of her own desire to be in harmony with her surroundings.

By now, however, by a process of psychological substitution, the need of turning the head has come to accompany *every* use of the right hand, so that she is unable to use her knife at the table without a turning of the head and an ensuing rigidity of the arm and head in the effort to arrest the torticollis and to accomplish the act she wishes. In writing, it is the same thing, and the case affords an example of writer's cramp mechanically produced by torticollis of mental origin, which, by a psychological association, has in turn become producible by any use of the hand or arm.

The cause of pain is the action of the muscles antagonistic to the turning movement, which she consciously seeks to prevent. Between the automatic desire to turn the head and the conscious effort not to do so, the muscles of the shoulder, neck and upper part of the chest are maintained more or less constantly in a state of powerful contraction, and the severe drag upon their attachments, combined with a state of fatigue, provokes the pain of which the patient complains.

Even at rest, the patient now holds the head somewhat to the right, and keeps contracted the neck and shoulder muscles on that side. The attempt to turn the head straight or to the left is not accompanied by *angoisse* strictly speaking, but causes a distress referable to the muscles at the right side and to the consciousness of her incapacity to freely perform the desired movement. She feels an actuating force stronger than herself. It is from such feelings in the credulous and superstitious that may arise the notion of possession by an external being, a *daemon*. If the woman's tic is not cured, I have no doubt that in course of time anguish will accompany efforts to suppress the movements; but at present the syndrome is not complete.

There are somatic factors in the case, for the tic is always much worse during the catamenia, when she has much pain, nausea and

sinking feelings of the heart with flushes, chills and headache, and often has to take to bed. These symptoms are said to be due to uterine mal position. She has also a marked exophoria, and had to abandon on account of dizziness her original work of spreading bills.

But the psychological factor is the main one, as will appear, for the torticollis is proportional to the insistence of the thought of her painful relationship with her fellow-worker; and when she succeeds in dismissing this from her mind, the tic rarely occurs. This, however, has been difficult, because she had no confident, not being willing to trouble her tired sister as had been her habit, and a clergyman to whom she was much attached, having left Washington. Hence, there was no relief from brooding over her grievance.

Treatment and Process.—I explained the genesis of her affection and gave a good prognosis. My first prescription was to take ten days of joy in the country and to try to be less hyper-conscientious during that time, paying no attention to her troubles or to the torticollis. Six days later she returned, not having followed the prescription, with pain in the head and the tic worse than ever. I gave her exercises in psychomotor discipline, consisting of dealing a pack of cards into two heaps while her head was turned away from the affected side, and cutting along lines ruled on a piece of paper. In a few days she greatly improved in performing these tasks, the tic greatly diminished and the pain in the shoulder disappeared.

But the fact that this improvement became less rapid, as was to be expected, so discouraged her that she relaxed her efforts during the exercises and substituted therefor a constant tension of the muscles in an attempt to rectify the abnormal posture of her head and neck. This created pain at the angle of the scapula, where the latissimus dorsi is attached, and she lost courage. She was advised to go out and relax, and to abstain from work at least another month. This she declared herself unable to do, and persisted in returning to work against advice. In consequence, the torticollis was greatly aggravated, and she gave up attending. I have learned recently that she had to remain away from work

for two months, during which she took chiropractic treatment, which improved her torticollis, but not the professional cramp; and she does her work entirely with the left hand, and her bitter mental attitude is worse than before.

Proceedings of Societies

AMERICAN PROCTOLOGIC SOCIETY.

Fourteenth Annual Meeting, Held at Atlantic City, N. J.,
June 3 and 4, 1912.

The President, Dr. John L. Jelks, of Memphis, Tenn., in the chair. Officers elected for the ensuing year:

President, Louis J. Hirschman, M. D., Detroit, Mich.; Vice President, Alois B. Graham, M.D., Indianapolis, Ind.; Secretary-Treasurer, Lewis H. Adler, Jr., M.D., Philadelphia, Pa.

Executive Council, John L. Jelks, M.D., Memphis, Tenn.; Louis J. Hirschman, M.D., Detroit, Mich.; J. Rawson Pennington, M.D., Chicago, Ill.; Lewis H. Adler, Jr., M.D., Philadelphia, Pa.

The place of meeting for 1913 will be at Minneapolis, Minn. Exact date and headquarters to be announced later.

The following were elected Associate Fellows of the Society:

Dr. Rollin H. Barnes, Metropolitan Building, St. Louis, Mo.; Dr. Barney J. Dryfuss, 7 W. 91st St., New York City, N. Y.; Dr. James A. Duncan, 1107 Broadway, Toledo, Ohio.

The following is an abstract of the principal papers read:

PRESIDENT'S ADDRESS.

RELATIONSHIP AND DUTIES OF "THE PROCTOLOGIST" TO THE PROFESSION.

By John L. Jelks, M.D., of Memphis, Tenn.

He stated that this Society was an innovation when organized—strange vessel on the high seas. A child of American medicine, it has now become a sprightly youth, with ambition and strength of purpose, having and exercising authority.

The medical world recognizes as authoritative the expressions of its Fellows in the field covered.

He admonished discretion, thorough description and perfection of technic. Hasty speech or carelessly written papers can not be erased or changed—as in their publication they become a permanent record.

He referred to the theories of our science, which were born of dreamers and nurtured by enthusiasts, and fancies no solid superstructure could be reared on foundations so infirm, and added that neither these, nor the honor, distinction, nor the gain they held out, should be sufficient to determine the surgeon to make merchandise of theories.

He called attention to the obstacles this Society had encountered, because of these fragile theories, which had previous to its existence, been set up as targets for those who were unfavorable to the development and progress of this specialty.

He considered the true surgeon and specialist as humanitarian, whose purpose in life is to save life, restore health and happiness, and admonished him to shield and protect his brother from the darts aimed to destroy.

He also referred to cancer in the rectum, sigmoid or colon, which may have been treated as of minor significance until metastases are so extensive as to preclude hope of a cure. He praised those Proctologists, who have with much patience and fortitude labored for and finally have overthrown that unfortunate assignment of malignant rectal and colonic cases to untimely graves.

He stated that much harm had been done by the profession in the establishment of drug habits among the people for the relief of constipation, as last year's symposium before this Society would show, and says the Proctologist is best equipped to study these cases, and arrive at the true etiology pointing to means of relief.

The American people are living in tin cans and cracker boxes, sparing time only to catch the next train, or meet the next market report, are storming their nervous systems with destructive toxins, filling sanatoria and health resorts with wrecks and lowering

the scale of human usefulness and intelligence. None can more early observe the impending catastrophe, or turn on the searchlight as the Procto-Enterologist, and scientist, who calls together the aids of chemistry, physiology, pathology and bacteriology and a fair degree of understanding as to the results of the methods and habits of life of the average American citizen, who is less careful in the selection of and preparation of his own food than that of his stock.

He complimented the Fellowship of the Society, which is limited to fifty and has forty-three members, and stated no similar number of men are banded together in the civilized world who can boast of greater attainment for the science of medicine, or for humanity, almost every member being the author of a book, and these are all standard text or reference books in this branch; most of them also have been inventors of valuable instruments, or appliances applicable to this specialty.

He referred to some of the research work done by the Fellows, and to the possibilities yet before them in Procto-Enterology.

He alluded to the intra- and extra-rectal and anal and colonic infections, the roll they play and the possible developments of vaccine therapy and antitoxins in combating them. He stated that each Fellow should carefully weigh his selected subject for these meetings, being mindful of the fact that the general profession is looking to this Society and its individual Fellows for facts, not fancies, for proven remedies and technics, and not fads.

The Society has attained an individuality, both national and international, and he reminded his Fellows that there is labor yet to perform. That they must retain their progressive spirit and enthusiasm, lest they lapse into a state of self satisfaction when retrogression will mean their ending.

He referred to the fact that few of the hospitals of this country permit additions to their staff of specialists in Proctologic work, hence the general surgeon and the general practitioner are doing the work in these institutions, about as these same men would do the Ophthalmologic work, etc.

He recommended the addition to the American Medical Association of a section in which the subjects, Gastro-Enterology and Proctology, or Procto-Enterology may be discussed.

He advised closer confinement of the Proctologists to this work, to the exclusion of general work, and believed this will receive from the profession greater respect for this specialty, and that fewer of this class of cases will be referred to the general surgeon, or be accepted by him for treatment.

Conservative Life Insurance Companies are now convinced of the necessity of paying attention to the rectum and colon and such instances as the writer's confidential reports to alert examiners of cases of Amebic infection, Adenomata, Papillomata, Syphilitic and Tuberculous diseases, which the examiner would have overlooked, and impressed him with this fact, and he wondered if these and similar instances had not brought to the minds of medical referees the possible advisability of subjecting all applicants for large policies to a plurality of examiners. He advised the change of name of this society to that of The American Procto-Enterologic Society, and stated not one of the Fellows of the Society had found he could eliminate from his work intra-abdominal intestinal work.

A REVIEW OF PROCTOLOGIC LITERATURE FOR 1911.

By Samuel T. Earle, M.D., of Baltimore, Md., Chairman
of the Committee on same.

Dr. Joseph F. Saphir, of New York City, the New York Medical Journal, 1911, Vol. 93, gives a description of "A Syringe for Local Anæsthesia in Rectal Operations."

Von Dr. Erich Schlesinger, Berlin, Deutsche Medizinische Wochenschrift, February 9, 1911, reports "An Air Pessary for Keeping in Place Internal Hemorrhoids and Prolapse of the Rectum."

Dr. Thomas B. Noble, Indianapolis, Ind., American Journal of Obstetrics, 1911, Vol 61, page 259, has devised an instrument

known as the "Anastomat" to facilitate the end-to-end anastomosis in extirpation of the rectum and sigmoid.

Dr. Dudley Roberts, Brooklyn, N. Y., the Proctologist, 1910, Vol. 4, gives a description of "A New Anal Speculum."

Dr. James F. Churchill, Chicago, Ill., Surgery, Gynecology and Obstetrics, Vol. XI, 1911, page 205, gives an interesting paper on "Rectal Anæsthesia."

Leslie W. Dryland, M. R. C. S. England, L. R. C. P. London, D. P. H. London Lancet, 1910, Vol. II, page 801. "An Operation for Prolapse of the Rectum."

Sidney Boyd replies to the above paper of Leslie Dryland's London Lancet, 1910, Vol. II, page 1242.

Dr. L. L. McArthur, Chicago, Ill., Journal of American Medical Association, 1911, Vol. LVII, page 363. "Rectal Prolapse."

Dr. Kenneth A. J. MacKenzie, Portland, Ore. Transactions of the American Surgical Association, 1911, Surgery, Gynecology and Obstetrics, 1911, Vol. 13, page 218. "Treatment of Fistula in Ano without Mutilation of the Sphincters."

A. Campbell Magarey, M.B. Adelaide, M. R. C. S., England. British Medical Journal, 1911, Vol. 2, page 71. "Hypertrophied Papillæ of Morgagni."

POST-OPERATIVE CARE OF RECTAL CASES.

By Wm. M. Beach, M.D., of Pittsburg, Pa.

Success in the solution of proctologic problems is measured by the degree of perfection in the restoration of functional conditions involved; we must remove the disease, but it is quite as important that we have a care to vouchsafe to our patients perfect function.

Post-operative developments that need our attention are:

1. The disturbance of the nervous system.
2. The disturbance of the vascular system.
3. Digestive derangement.
4. Local conditions.

Vascular aberrations are shown by (a) hemorrhage, (b) infection.

Gastro-intestinal derangement are (a) nausea, (b) constipation, (c) ampullar impaction.

The local care of wounds should be inspected daily by the operator.

If patients are given proper post-operative care, their dread of radical cures would quickly subside, and rectal surgeons would escape untoward sequelae they may be compelled to record.

PATULOUS ANUS: ITS CLINICAL SIGNIFICANCE.

By Alfred J. Zozel, M.D., of San Francisco, Cal.

The condition of patulous anus results from an abnormal loss of tone in the sphincter muscles, which may be due to either a fault intrinsically within the muscle, or to some disturbance in its nerve supply. When purely muscular the cause may be a direct injury to the muscle; an infiltration by a malignant or a syphilitic growth; a participation in a general muscular weakness; or the presence of a foreign body in the rectum which prevents the muscle from completely contracting. When the nerve supply to the sphincters is at fault the causative lesion may be either central or peripheral.

Complete fecal incontinence does not necessarily follow when the anus becomes patulous. The external sphincter, when but slightly affected, sometimes is assisted in performing its function by an extra effort of the will and through augmenting the muscle's action by strongly contracting the glutei muscles and bringing them together.

A brief report of a few very interesting cases of patulous anus is given to illustrate the different causes of this condition, among them being a case of infiltration of the sphincters by a carcinomatous growth low down in the rectum; a case, the result of pederastic practices; a case, the result of a participation in the general alcoholic neuritis; cases where it occurred in low intus-

susception of the bowel in children; and two cases where it appeared as one of the early signs of locomotor ataxia.

THE SURGERY OF COLONIC CONSTIPATION.

A Report of Thirteen Cases.

By Louis J. Hirschman, M.D., of Detroit, Mich.

After presenting the histories, radiographs and reports of operative treatment of thirteen cases of obstipation due to colonic obstruction, dilatation, stricture and adhesions, Dr. Hirschman has formulated several principles in dealing with his cases requiring colonic surgery. They are epitomized in the following conclusions:

1. Most cases of chronic constipation are colonic in origin and many are obstructive in type.
2. Many cases of so-called chronic constipation are therefore really colonic obstipation.
3. Many cases of colonic obstipation suffer from chronic dilatation of the colon with or without ptosis.
4. Radiography is a most vital necessity in the diagnosis of all cases of chronic interference with bowel function. Its negative value may be greater than its positive.
5. A chronically, over-distended colon, whether adherent or not, never again becomes a normally functioning bowel.
6. Intestinal adhesions usually tend to recur in increased intensity and adhesions only cause symptoms when put under stress or tension.
7. The prevention of tension is physiologic rest to the affected organ, and colonic rest is obtained only by colectomy, colostomy, or exclusion.
8. Colectomy as advocated by Lane is an operation seldom advisable and has many obvious objections from the standpoint of patient and physician. It is too grave a procedure to be undertaken except in the most aggravated cases.

9. Strictures, neoplasms and other obstructions should be removed by excision of the diseased tissue and lateral anastomosis of the bowel.

10. Exclusion by ileo-colostomy is safe, easy to perform and most satisfactory in the restoration of normal peristalsis and consequently normal health.

11. Results speak more eloquently than words. After an experience with nearly fifty cases requiring exclusion or resection of the colon for obstructive constipation with but one failure, I feel fully justified in recommending it to your careful consideration in all cases of aggravated colonic obstipation, whether congenital, post-operative, or dependent on some mechanical obstruction or narrowing of the bowel.

THE ROENTGENOLOGIC METHOD OF EXAMINING CASES OF CONSTIPATION AND OBSTIPATION—A METHOD OF VISUALIZATION OF ABDOMINAL LESIONS OF THE INTESTINAL TRACT.

By Arthur F. Holding, M.D., of New York City, N. Y.

The author noted that current text-books on diagnosis written by eminent authorities are still copying cuts which were drawn by some artist rather than by an anatomist. Let us hope that the striking proof furnished (by the X-rays) of the fallacy of such teaching will be effective, and perhaps not one of the least results will be to cause true illustrations to be placed before our students' eyes.

The normal position of the colon and the parts of the intestine that can ordinarily be visualized by means of bismuth injecta and the X-rays, are:

(1) The first portion of the duodenum; (2) the jejunum; (3) the ileum; (4) all parts of the colon; in some cases the second and third portions of the duodenum and the appendix, can be visualized.

The accuracy, reliability and interpretation of findings by this method, however, may well receive our careful attention.

In the first place, this method does not cause gastro-intestinal symptoms, such as nausea, vomiting, diarrhea, constipation, gastro-intestinal or general symptoms, other than are present when buttermilk alone is ingested. It is therefore logical to assume that the buttermilk-bismuth mixture does not irritate the mucous membrane, and gives a true picture of the motor activities of the patient's intestines.

By fluoroscopy and by radiography in the erect or prone positions, or both, an accurate outline of the lumen of the tract can be obtained, especially where there is any obstruction to the onward progress of the intestinal contents. The individual peristaltic waves can be accurately registered on a special photographic emulsion that is far more sensitive than the human retina, and the progress of the peristaltic waves can thus been seen functioning under normal conditions, the patient and his abdominal contents not relaxed by a general anæsthetic; the secretions and mobility not disturbed by the presence of an irritating foreign body, such as a stomach tube; the conclusion not based on inference deduced from chemical reactions of juices obtained by abnormal and irritating measures. The organic outline obtained in X-ray plates is even more conclusive and reliable than the information obtained by the sense of touch, whether that be applied over the intact abdominal wall or to the viscera laid bare by an exploratory incision. The radiographic emulsion and the retina are the two most sensitive methods of observation possessed by man, far outranking in their acuteness either the drum, membrane or the sense of touch. It has been contended that the abdominal operation was more accurate than an X-ray examination, because it laid bare the "naked truth," the finality of this argument is based more on the sound of the words than in fact, as anyone knows who has had an opportunity to use both methods on the same case.

On the other hand, there is great danger of arriving at wrong conclusions in using the X-Ray method, especially when the examination is based on too few plates or is only an examination of a suspected part of the 30 odd feet of intestinal canal.

We must not let seniority interfere with our recognition of the superiority of methods employed by us for diagnosis. No progressive proctologist or surgeon should depend on any one method, but should use them all in examining cases, and in obscure cases he should not hesitate to insist upon supplementing the more common methods of examination with a radiologic examination, regardless of the expense involved.

The various lesions and conditions that have been successfully shown by the X-ray methods are: atonic and spasmodic constipation; congenital anomalies of the tract, such as non-rotation of the cecum and narrowing or insufficiency of the ileo-cecal valve; adhesions of kinks, with or without adhesions (including Lane's) ulcers; tumors within the canal and tumors pressing upon the intestines from without.

It must be borne in mind that a palpable tumor disappearing after the administration of an enema or a cathartic, even if followed by improvement in the patient's condition, is not proof that the tumor was feces.

The Roentgenologic method of clarifying difficult conditions present in patients will no doubt be gladly welcomed and widely utilized by surgeons, who, as a class, deserve our greatest respect and admiration for their courage in attacking many ordinarily undiagnosible conditions by cutting boldly into the abdomen and making their diagnosis by inspection and thereupon instituting impromptu surgical procedures in order to correct conditions found. Many times the condition found within the abdomen is entirely different from that which was expected. When these difficult situations can be accurately known before the operation is begun; when the surgical procedures can be accurately predetermined; when much time (previously lost exploring the abdomen) can be saved; when the duration of the patient's anæsthesia can be proportionately shortened; when the surgeon will be saved the tremendous nervous strain and responsibility of emergency decisions and procedures; the surgeon must recognize that his operative statistics will necessarily be better, his patients are going to recover quicker, and more of them, and finally the years of a surgeon's own life and usefulness will be increased.

The only great drawback to the general adoption of this method is its necessarily great expense.

VALVOTOMY.

By George B. Evans, M.D., Dayton, Ohio.

Valvotomy as a factor for the relief of proctitis.

Valvotomy as a factor for the relief of obstipation and constipation.

Valvotomy as a factor for the relief of distinct and isolated ulceration of the distal side and adjacent to the valve.

Valvotomy as a factor in the elimination of bladder and prostatic symptoms reflexly.

The location of the valves. Every case of valvular trouble is accompanied by pathological changes in the valves, and if in the valve, then in the adjacent tissues.

Valvular obstructions are prolific of more trouble than we give them credit for.

Valvular obstructions are causative factors in the production of obstipation in a large per cent of our cases.

Valvotomy is a justifiable operation, as it not only relieves obstipation and constipation, but often causes reflex and neurasthenic symptoms to disappear; frequently ameliorates and even cures proctitis, and by virtue of the drainage it secures, lessens the tendency to toxemia from intestinal origin.

(To be concluded in next issue.)

Extracts from Home and Foreign Journals.

SURGICAL

KOCHER'S PRESENT WORK IN STRUMECTOMY.

At the close of an article on goiter and its treatment Kocher states that he completed his fifth thousand last March. In one series of 603 uncomplicated cases, many of whom were, however, severe, he did not lose a patient. There were 26 cases of malignant struma in the series and 19 second operations. In a series of 91 cases of intrathoracic struma he lost three patients, but in none of the cases was the operation itself the cause. Thus in all cases usually termed plain goiter there was practically no mortality from the operations in 736 interventions. The goiter heart of ordinary goiter is no longer a contraindication if the operation can be done seasonably. There is no summary of his complicated cases in which there was doubtless more or less operative mortality. The author closes with the statement that medical treatment is sufficient for slowly progressive goiters which do not cause stenosis, and often yields brilliant results.—*Medical Record*.

RESECTION OF SPINAL NERVE ROOTS.

Foerster here brings down to date the history of the operation generally called by his name, stating that it has been done to relieve tabetic crises in forty-four cases; the resection was not extensive enough in some so that the pains recurred later; in some other cases crises developed in other nerve regions. Five of the patients died, and no benefit was obtained in three cases. Another cause for failure may be that in certain cases the vagus is responsible for the crises. Rhizectomy has been done further for spastic paraplegia in fifty-nine cases, with benefit in forty-six, no benefit in five, and eight patients died. The operation can do no good unless the disturbance is of actual centripetal origin; this excludes athetosis, chorea, convulsive tic, motor spasms, etc. The

affection must be stationary or only very slowly progressive. Rapidly progressing contra-indicate the method. Careful oversight and training afterward are indispensable and where they are not possible the method had better not be applied. He advises to sever nerves enough to answer the purpose, but to spare always the third or fourth lumbar nerve, as this is in the knee extension reflex.—*The Journal of the Am. Med. Ass'n.*

MEDICAL

NUCLEIN IN SCARLET FEVER.

Writing in *Russkii Vrach* for March 13, 1912, M. G. Molykoff tells how he treated altogether 90 cases of scarlet-fever, with sodium nucleinate, which was given hypodermically. Seven of these patients reached the hospital on the second day of the disease. Nuclein was administered, and the injection caused increased leukocytosis, and, as a result, the temperature dropped to normal in from one to three days, the disease apparently being aborted in this group. None of these children died.

To another group belonged children who reached the hospital on the third to sixth day of the attack. While the nuclein did not abort the scarlet fever in these cases, yet the mortality was lower in the 71 members of the group than is usually the case in Russia. Three children of this group died, 2 from phlegmonous inflammation of the neck and 1 from cardiac failure.

The third group comprised those who reached the hospital late in the disease. These were few in number and no favorable or unfavorable effect followed the administration of the sodium nucleinate.

Molykoff's experience certainly demonstrates the value of beginning the treatment with nuclein early in attacks of scarlet fever and other contagious diseases. It undoubtedly helps to cut short the course of the disease. Other indicated remedies should be employed, of course, special attention being given to the toilet of the alimentary canal, the care of the skin and throat, and the reduction of hyperthermia.—*The Am. Journ. Clinical Medicine.*

REST IN TUBERCULOSIS.

Ill-timed exercise is said to have killed more tuberculosis individuals than all other pernicious factors combined. In the *Boston Medical and Surgical Journal*, for May, Dr. N. B. Burns attempts to emphasize the importance of rest as a therapeutic agent. Rest is necessary in the acute period of the disease; exercise after its subsidence.

Exhaustion resulting from effort leads to a lack of resisting power and the inflammation is then permitted to spread unchecked through a larger and larger area of lung tissue.

Exertion having thus stirred up a smoldering fire, if continued will cause the patient to be taken acutely ill with what is called "grippe," a "bad cold," or "bronchial pneumonia," although really an extension of the tuberculous processes.

This is the first danger signal and should be noticed; if only a rest of a few days is taken there is apt to be a recrudescence of the trouble. From this we may conclude that it is necessary for the patient to take a prolonged rest in order that healing and encapsulation may take place. With an evening temperature of 100° plus, rest in bed is the only way to prevent the occurrence of more troublesome symptoms.

The individual should respect his physician's advice even to the minutest detail, for, whereas too much rest is usually easily remedied the results of excessive exercise may be irretrievable.—*The Lancet-Clinic*.

ANTI-TYPHOID INOCULATION.

The conclusion Leishman has come to with regard to the use of typhoid vaccine in the treatment of actual cases of enteric fever is that it is a most valuable means of treatment and that the vaccine therapy of these general infections will in time prove of great use. His experience in treatment was that small doses did no harm, but, at the same time, did no good. The dose was then increased from 50 to 100 millions every third day, with which excellent results have been obtained. All who had to do with the

patients thought they had benefited greatly. The enteric facies disappeared, the patients said they felt better, and, in two or three cases, they even asked that the vaccine should be repeated. Also, it seems to reduce the size of the spleen and to increase the flow of urine, which is thought to be a favorable sign. Shortening of the fever is difficult to judge. As to the temperature, the result of vaccination is to raise the temperature in the following twenty-four hours about 1 F. over what might have been expected; but it soon falls, and to a 1 degree lower point than before inoculation. About the third day after inoculation it tends to rise again; another injection is given, and the same result follows. And, finally, the temperature touches normal, and remains there. As to the relative advantages of using a stock vaccine or an autogenous vaccine Leishman thinks stock doses appear inefficient, and, as far as our present knowledge goes, he would recommend starting at a dose of 50 millions, and cautiously increasing it to 100 or 150 millions. In his opinion the vaccine treatment of enteric fever is sound practice, and will grow in favor as time goes on.—*The Journal of the Am. Med. Ass'n.*

HIGH BLOOD PRESSURE AND THE COMMONER AFFECTIONS OF THE ARTERIES.

H. French is certain that high arterial pressure can be reduced safely only when the muscle of the arterial coats is still muscle, though it may be out of training and stiff. As long as it is muscle it may be rendered supple again by arterial gymnastics, and so brought back under the control of the vasomotor system, to the great relief of the heart. When, however, the tunica media of most of the arteries, particularly those of the splanchnic area, is fibrous and no longer muscle, a high blood pressure becomes a necessity if the patient is not to be permanently invalided. If one relies solely upon the "toxic" and the "increased peripheral resistance" theories of arteriosclerosis and high blood pressure, one may often treat the patient on the wrong lines. The correct lines of treatment are as follows: (1) Prevention by moderation in eating and drinking, a due alteration of brain work with physical exertion daily. (2) Relief in the earlier stages by carefully con-

sidered steps that may be classed together under the heading of "arterial gymnastics." (3) Recognition of the fact that when the stiffening stage has passed and fibrosis is already established a high blood pressure is to a greater or less extent a necessity; that it has to be maintained by the heart; that it could be lessened by lessening the work of the heart, as by invaliding the patient or putting him to bed; but that if the patient is to continue life in anything like its full activity the heart must be enabled to maintain a high blood pressure, for which purpose iodides, nitrites, and so forth are relatively useless; cardiac "training" by regulated massage, exercises, being far more important, and the chief drugs to rely on when the heart symptoms are well developed being those which increase the force of heart beat, especially full doses of tincture of digitalis.—*Medical Record*.

SOURCES OF TUBERCULOUS INFECTION.

Knopf, (*N. Y. Med. Jour.* June 29, 1912), estimates that of the 150,000 who die annually from tuberculosis in the United States, 50,000 are bread winners. If a value of only \$1,500 is set on each life the loss to the community reaches \$75,000,000. Another third probably are school children. Making the average duration of life only 7.5 years, and figuring the cost to the parents of each child as only \$200 per annum, the community loses another \$75,000,000.

Children who live in close association with tuberculous parents are found to be tuberculous in 51% of the cases.

Biggs, Brouandel, Naegeli and many others assert that the vast majority of city people living in cramped quarters have or have had tuberculosis. Knopf believes that at least 25% of the children of the masses have an undiscovered tuberculosis. In large families it is nearly always the later born who contract the disease. The age of the father, physical condition of the mother and poverty are all factors.

Direct bacillary transmission through the placenta is rare but occurs perhaps more frequently than our statistics would seem to indicate. However, postnatal infection is the most frequent

cause. Alcohol is a strong predisposing cause. There is no doubt that the infection is not infrequently transmitted by the mother's milk. While the bovine type may be considered a negligible factor in pulmonary tuberculosis of the adult, in children it is responsible for a large percentage of cervical, alimentary and bone and joint infections. The next most frequent primary sources of infection in childhood arise from the bacilliferous saliva and sputum of the tuberculous individual in close and prolonged contact with the child.

Among the rarer modes of infection in the adult are mentioned: The tuberculous cigar maker, glass blower, waiter, maid, bookkeeper, kissings of relics among Roman Catholics, inoculation by tattooing and circumcision. Poncet of Paris asserts that he has found bacillus in the perspiration of consumptives.

As one method of combating the disease Knopf recommends vasectomy in tuberculous cases who insist upon marrying.—*Buffalo Medical Journal*.

PITUITARY EXTRACT.

Of the various organo-therapeutic agents which have been carefully studied and brought into prominence during recent years, none is more interesting than the infundibular extract of the substance of the pituitary gland.

Having a wide range of usefulness, this agent promises to become an important addition to those measures which have been used more or less successfully in various obscure conditions.

In an attempt to solve the problem of overcoming the temporary paralysis due to exposure of the intestines following laparotomies, Birdwell (*Clin. Journal*, September, 1911), tried the injection of pituitary extract in a series of twenty uncomplicated cases. He found the results gratifying, the drug having had a marked effect on the muscular coats of the intestines. None of the patients so treated, complained of flatulence and the early passage of flatus in each case, was a marked feature, as a rule. Doses of 0.5 to 1 c.c. were injected intramuscularly, at intervals of 6 hours, for one to three days, until results were obtained.

It has been experimentally proven that pituitary extract not only stimulates the muscles of the bladder and uterus, but also the independent nerve supply of these organs. Hoffstatter (Wien Klin-Woch. 49, 1911) was able to overcome post-operative atony of the bladder in a large number of gynecological cases, by the intra-muscular injection of from 1-2 c.c. pituitrin, thereby doing away with the use of the catheter. Thus he added much comfort and safety to the patients. Each injection was followed by voluntary urination in from 15 minutes to an hour.

In obstetrical practice, pituitary extract has found favor with many. It may be tried, both in the induction of delayed labor and as an adjunct to ergot in post-partum atony of the uterus and post-partum hemorrhage. It would seem, however, that the drug is much more effective in inducing contractions of the uterus at full-term, than during the earlier months of pregnancy. In a case observed recently by the writer, a primipara, twelve days overdue, was given an intramuscular injection of 1 c.c. of pituitrin without effect; five hours later, 2 c.c. of pituitrin similarly injected was soon followed by good contractions of the uterus which continued throughout labor. In this case, the introduction of hydrostatic bags to induce labor was avoided.

Aside from the uses described above, pituitary extract, on account of its property to raise and maintain blood pressure over a considerable period, may be used with advantage in shock and collapse. It is also said to increase greatly the flow of urine and may thus be employed in cases of anuria, providing the blood pressure of the patient is not high. The extract of the pituitary gland appears on the market as pituitrin and as pituitary (infundibular) extract. The average stated dose is 0.5 to 1 c.c., given preferably by the intramuscular method.—*Medical Review of Reviews.*

OBSTETRICAL

NEUROPATHIES AND PSYCHOPATHIES OF GENITAL ORIGIN.

L. M. Bossi advocates the gynecological examination of every woman who comes before a court of law for the commission of a crime, whether it be stealing, or a crime of violence, or attempted suicide, and that it be ascertained whether she has any genital anomaly before she is tried or condemned. In the same way every woman who becomes insane should go through an examination for the presence of utero-ovarian anomalies before she is sent to an insane asylum. If she has genital troubles she should be treated and will often recover entirely. It is not the serious lesions like cancer, fibroma, and peritonitis that cause alienation, but the slow, insidious infections, and the displacements that render the life of the victim insupportable, and make her unable to do her work or mix with society, that by the presence of a slow infection and the symptoms of autointoxication affect the nervous system. The author cites cases known to him and treated by him in which kleptomania occurred only at the menstrual period, which with its added nervous irritability made a criminal of the woman. Many violent crimes are the result of such a condition eventuating in a sudden access of insanity from some slight excitement occurring at a neuropathic period. It is the duty of physicians to recognize these facts and endeavor to educate the public so that these persons should receive proper gynecological treatment, instead of being incarcerated in prison or committed to asylums. Under proper treatment many a hysteric, epileptic, or insane woman will recover from both her uterine and her mental disease.—*Medical Record*.

GYNECOLOGIC TUBERCULOSIS.

Labhardt's hundred cases of tuberculosis of the genital organs or peritoneum or both, 1900-1910, teach the importance of individualizing treatment, combining conservative and operative measures as indicated. An operation is scarcely advisable in the

severe cases with complications and mixed infection, as evidenced by high fever. It is not needed further in the mildest cases, as the tuberculosis readily improves under conservative measures. If these fail, then operative treatment should be advised. Fever always renders the outlook graver. The operation should be as radical as possible, avoiding contaminating the abdominal cavity or wound with tuberculous material. With tuberculous peritonitis alone, conservative measures should be the rule. If there is much ascites the fluid should be evacuated by a laparotomy, not puncture; this permits oversight of the ovaries and tubes. The laparotomy must not be regarded as a certain cure in itself, not even in the form with effusion. The experiences with injection of camphorated oil before and during the operation have been encouraging to date. None of the patients died from the genital tuberculosis, but tuberculous peritonitis may prove fatal alone. The patients generally succumb to the progress of tuberculous processes elsewhere, in the lungs, as a rule. The results reported seem to indicate that the removal of the pelvic focus permits recuperation and checks metastasis. Of the ninety-eight patients followed to date, 71.5 per cent of the fifty-seven women operated on are still living and 54.8 per cent of those treated with conservative measures; all but 5 per cent of the first and 14 per cent of the second group have their earning capacity unimpaired. The symptoms of genital tuberculosis resemble those of any affection of the adnexa; pain is the rule, more or less spasmodic as the tubes contract. Adhesions also induce pain, increasing as the acute phase of the onset subsides. Fever was noted in 50 per cent of the cases; more frequent and higher when the peritoneum was involved. About 20 per cent of the nonfebrile patients have died and 50% of those with fever.—*Jour. of the Am. Med. Ass'n.*

HERMAPHRODITISM AND TUMORS OF THE SUPRARENAL BODY.

Auvray (*Revue de gynec. et de chir. abd.*, April, 1912) writes about a gynandroid or pseudo-hermaphrodite woman, aged 72, who died of intestinal obstruction after refusing surgical aid. There was a uterine fibromyoma, weighing over 3½ lbs. It oc-

cupied the entire body of the uterus, and had pressed on the bowel at the pelvic brim. The vagina was very narrow and joined the urethra, the clitoris was peniform. The ovaries were atrophied, but traces of old corpora lutea were found in their stroma. The left suprarenal body was converted into a tumor, which seemed to be cystic, but proved to be a solid adeno-angeio-lipoma. It was of the size of a cocoanut. Auvray, after showing that many instances of uterine tumors in pseudo-hermaphrodites have been reported, further reminds the gynecologist that hyperplastic tumors of the suprarenal body have been found coexisting with hermaphroditic malformations. No fewer than eight cases have been published with recent years. Apert in particular has recorded clinical evidence showing the different results of this coincidence according to the age of the subject. It is when the disease of the suprarenal body begins before birth in a female fetus that hermaphroditic changes develop in the genital tract itself. The uterus remains normal, at least above the cervix, but the external organs assume the male type, and a prostate can usually be distinguished. When the suprarenal disease does not appear till childhood, then puberty is premature. In adult life the advent of suprarenal hyperplasia is associated with the cessation of the catamenia and the growth of a beard; hair also appears all over parts naturally smooth. Adiposity is another complication. After the menopause extreme corpulence seems to be the only symptom, but clinical evidence of late hyperplasia of the suprarenal body is scanty. Glynn, of Liverpool, Auvray adds, confirms Apert's views. Auvray finds that other tumours of the suprarenal body, such as blood cysts (*Proc. Roy. Soc. Med.* vol. i, Surgical Section, and Treu, thesis, Jena, 1909) and malignant and tuberculous growths, bear no distinct relation to sexual peculiarities.—*Pacific Medical Journal*.

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at \$1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

The fourth annual meeting of the American Association of Clinical Research will be held in New York City, at the Academy of Medicine, on November 9, 1912.

The sessions will be held from 9 a. m. to 1 p. m., from 3 p.m. to 6 p.m., and from 8 p. m. to 10 p. m. The evening session will be open to the public.

Notable contributions on the Negri Bodies, on certain Fluids for Tubercle Bacilli in the Urine, on Adjustment and Function, on Psychoanalysis and Traumbedeutung, on a Pandemic of Malignant Encapsulated Throat Coccus, on The Single Remedy on Indicanuria and Glycosuria, on Disease Conditions expressive of Correct Diagnosis, on Biochemic Problems, on the Two Most Far-reaching Discoveries in Medicine, and others are to be given. Every member of the Association is cordially invited to contribute a paper. The title should be sent at once to the Permanent Secretary so that the program may be completed.

As soon as completed, the program will be mailed to you. Please make an effort not only to contribute a paper, but to be present at the coming meeting, to bring your friends, and to assist in the most important movement of medicine as represented in the aim of our Association; the systematic, scientific investigation and advancement of medicine by conclusive clinical and clinically-allied methods.

Please invite your friends to become members. Your support and that of your friends will be cordially appreciated.

DENTAL INTERNE (MALE).

Government Hospital for the Insane.

September 4, 1912.

The United States Civil Service Commission announces an examination on September 4, 1912, at the places mentioned in the list printed hereon, to secure eligibles from which to make certification to fill a vacancy in the position of dental interne (male), at \$600 per annum, with maintenance, in the Government Hospital for the Insane, Washington, D. C., and vacancies requiring similar qualifications as they may occur, unless it shall be decided in the interest of the service to fill the vacancy by reinstatement, transfer, or promotion.

The department states that it reserves the right to terminate the appointment at the expiration of one year of service if it is deemed advisable to do so.

In addition to the many interesting cases presented, the dental interne is given an excellent opportunity for study and for doing experimental research work in the pathological, histological, and other laboratories of the institution.

The examination will consist of the subjects mentioned below, weighted as indicated:

<i>Subjects</i>	<i>Weights</i>
1. Letter writing (the subject matter on a topic relative to the practice of dentistry)-----	5
2. Anatomy and physiology (general on these branches, also with special reference to the teeth, mouth, and head)--	10
3. Chemistry, materia medica, and therapeutics (the preparation, properties, and reactions of chemicals, crude drugs and their preparations, their action and application, with those of other therapeutic agencies)-----	15
4. Dental pathology and oral surgery (the morbid processes incident to diseases and injuries of the teeth, mouth, and oral surgery (the morbid processes incident to diseases and injuries of the teeth, mouth, and contingent structures, and their surgical treatment)-----	20

5. Operative and prosthetic dentistry (the detailed technics of general and special operative and laboratory work) _	25
6. Bacteriology, histology, and hygiene (the cultivation, isolation, demonstration of bacteria, the principles of sterilization, mounting specimens, use of microscope, the principles of general and oral hygiene, etc.-----	10
7. Orthodontia (local and constitutional irregularities in growth and development of the teeth, and their correction) -----	15
Total-----	100

Applicants are required to be graduates of regularly incorporated dental colleges, and applications will not be accepted from persons who have been graduates more than two years.

All statements relating to training, experience, and fitness are subject to verification.

Applicants must be unmarried.

Age limit, 20 years or over on the date of the examination.

This examination is open to all citizens of the United States who comply with the requirements.

This announcement contains all information which is communicated to applicants regarding the scope of the examination, the vacancy or vacancies to be filled, and the qualifications required.

Applicants should at once apply either to the United States Civil Service Commission, Washington, D. C., or to the secretary of the board of examiners at any place mentioned in the list printed hereon, for application and examination Form 1312. No application will be accepted unless properly executed and filed with the Commission at Washington. In applying for this examination the exact title as given at the head of this announcement should be used in the application.

As examination papers are shipped direct from the Commission to the places of examination, it is necessary that applications be received in ample time to arrange for the examination desired at the place indicated by the applicant. The Commission will therefore arrange to examine any applicant whose application is received in time to permit the shipment of the necessary papers.

Issued July 31, 1912.

SEAMAN A. KNAPP MEMORIAL AND FARM BUILDING. --

SOUTHERN BUILDING.

WASHINGTON, D. C., July 23, 1912.

Editor Journal of Medicine and Surgery, Nashville, Tenn.:

DEAR SIR:

The Seaman A. Knapp Memorial Committee has decided by a unanimous vote to raise \$150,000 for a properly equipped farm and a memorial building to be associated with the Seaman A. Knapp School of County Life, connected with Peabody College. The General Education Board recent gave the Seaman A. Knapp School of County Life \$250,000, the interest on which is to be used for running expenses. Our committee is attempting to provide a building in which the instruction may be given and a farm upon which it may be made more practical.

The great task of improving conditions of living on the farm, of making life in the country more productive and more humanly interesting, which Dr. Knapp inaugurated, and which his representatives are carrying forward today, presents one of the most vital and pressing problems in Southern life and citizenship. This school is needed to aid the one thousand farm demonstration agents now working in the South, as well as to supply the demand for an increase of such workers who are expected to carry on several services already begun. It is needed to assist the rural school and the rural teacher. It is to be a rallying point for demonstration agents, county superintendents of education and other workers. It is to be a clearing house for rural school ideas and plans. It is to furnish a model country school, home farm, model barns, fences, gates, implements and general equipment at reasonable cost. The farm will be located several miles from Nashville.

There has not been a name to which the farmers, their sons and their daughters in the South are so much indebted as that of Dr. Knapp. His practical wisdom, his sane counsel, and his untiring energy have reached hundreds of thousands of families. He has made agricultural pursuits more worth while, and he has inaugurated a work which must not be allowed to decline. Every family

in the South has profited by his advice; every teacher and every school child have been benefited by his teachings; every commercial establishment and every industrial institution have increased their earnings because of the increased productivity and efficiency which the great movement which he introduced brought about.

It is preëminently fitting, therefore, for us to call upon every grateful citizen to join in the establishment of this most practical and helpful memorial.

We have appointed Mr. Thomas A. Early, of Mississippi, as the representative of the committee, who will coöperate with us in presenting the claims of this worthy undertaking.

We are writing to ask that you assist him and us in this enterprise. Will you please write Mr. Early, Southern Building, Washington, D. C., suggesting how he may best proceed in interesting the people in your section?

Will you join us in memorializing the service and extending the work of this great friend and benefactor of the South?

Sincerely yours,

O. B. MARTIN,
For the Committee.

HONORARY DEGREE CONFERRED.

At the eighty-first annual commencement of Wesleyan University, at Middletown, Conn., held on June 19, the degree of doctor of laws was conferred upon Dr. Amos J. Givens, proprietor of Givens' Sanitarium for Nervous Diseases at Stamford, Conn.

We regret very much the omission in this number of the Journal editorial matter and book notices which had been prepared but copy of which was lost in transmission to the publishers. The loss was discovered too late for restitution in this number.

Publisher's Department

ENTEROCLYSIS.

In Dr. Robert Coleman Kemp's valuable manual upon Enteroclysis, Hypodermoclysis and Infusion, there is a brief introductory chapter by William H. Thomson, M.D., LL.D., from which the following is a quotation:

"Lavage of the invisible cavities of the body in inflammatory states of their lining, mucous membranes has justly taken rank among the most effective of modern remedies measures. In the case of the rectum and lower bowel, however, the greatest number of advantages results follow from this procedure, not only by improvement in local conditions, but still more by effects obtainable through certain physiological relations upon the general circulation, as well as others secured through important nervous associations with contiguous organs."

We merely quote the above in order to give the opinion of such an eminent authority as Dr. Thompson upon the value of enteroclysis.

Bearing upon this subject the following clinical reports will be of interest:

S. Newmayer, M. D., Philadelphia, Pa., states: Among the varied causes of convulsions none play a more frequent and important part than autointoxication. They are more frequent in children, due generally to a possible overfeeding, improper food or constipation. The intestinal canal contains a variety of toxins derived from the ingesta, bile and putrid material. There is continuous absorption from the intestines, including the taking up of toxines.

In the acute infections, where convulsions is oftentimes a forerunner, autointoxication from the intestinal tract undoubtedly is of no minor importance. Infections are the result of microbes, and we know these bacteria produce something injurious to the system—they elaborate poisonous ptomaines or toxic substances. Nature tries to rid the body of this poison through its various channels of elimination, one of which is the intestinal canal.

It is here we can aid Nature with our antiseptics. The value of internal intestinal antiseptics I believe is greatly over-rated. Many of these drugs are soluble and absorbable, and those that are not are so often given in Thymoline 50% strength and ordered fifteen or twenty drop doses of Glyco-Thymoline in hot water every twenty minutes. About nine o'clock in the morning the child fell asleep and slept soundly for nine hours, longer than it had ever done. I then decreased the dose of Glyco-Thymoline. Child began to gain rapidly and weighed at the end of a month about twenty-five pounds, and was gaining. I have used Glyco-Thymoline in other cases with equal satisfaction.

J. N. Landry, M.D., Fall River, Mass., states: Male child, age 14 months, had diarrhea for two days when I was called. Milk was to be discontinued altogether and water only (boiled) given to the child. Dejections were very frequent and watery. I prescribed calomel and salol aa gr. 53, two doses one hour apart. I then ordered a rectal injection of Glyco-Thymoline and water to be repeated twice a day. The child was given internally—

℞ Bismuth Salicyl. -----gr. ii.
 Glyco-Thymoline -----gtt. xx.
 Elix. Lactopep. -----q. s. ft. 3 i.

For one good day and a still better night. The next day he was all right and is now as healthy as ever.

Kress & Owen Co., 210 Fulton Street, New York, U. S. A. Manufacturers Glyco-Thymoline and K. & O. Nasal Douche, G. T. Eye Both (aluminum).

Agents for Great Britain: Thomas Christy & Co., 4-10 and 12 Old Swan Lane, London, E. C.

Canadian Agents: Lymans, Limited, Montreal, and all wholesale druggists.

French Agent: Samuel T. Fletcher, 10 Chaussee d'Antin, Telephone 324-71, Paris.

Glyco-Thymoline can also be obtained from the wholesale and retail Chemists and Pharmacists in all civilized countries of the world.

DOCTOR, REMEMBER.

Dioziburnia is the most efficient uterine tonic, alterative, antispasmodic and anodyne, indicated in anemia, parturition, leucorrhea, menorrhagia, subinvolution, dysmenorrhea, miscarriage, vesical tenesmus, diarrhea, dysentery, chlorosis, ovaritis, cholera morbus, climacteric diseases, endometritis, uterine engorgement, metrorrhagia, prolapsus uteri, threatened abortion, puerperal convulsions, vomiting of pregnancy, relaxed condition of the uterine.

Neurosine is the standard neurotic, anodyne and hypnotic. Contains no opium, morphine, chloral or other deleterious drugs. Indicated in all neuroses, migraine, hysteria, spermatorrhea, uterine congestion, shingles, opium habit, chorea, neuralgia, Asthma, neurasthenia, herpes, delirium tremens, whooping cough, seasickness, and all reflex and colulsive neuroses.

The True Nerve Calmative.—The Remedy Par Excellence in restlessness of fevers, producing natural sleep. *Neurosine is almost a specific in epilepsy.*

In Tongaline, sodium salicylate from the natural oil is combined with tonga, colchicum, black cohosh and pilocarpin, whereby the organs of elimination are greatly stimulated, so that prompt and efficient results are secured without the necessity of such large doses of the salicylates as to cause any harmful effects.

THE VALUE OF AN EFFECTIVE ALTERATIVE IN
NEURASTHENIA.

Nine-tenths of the cases of neurasthenia which present themselves are due to the blocking up of the system with the products of malassimilation. It is not so much a tonic, and stimulant regime that these cases demand, although that is useful later on, as a course of treatment designed to wake up their lazy emunctories. Bowels, kidneys, liver, sweat glands, all require stimulation, and Iodia is *par excellence* the remedy to produce this result. This sort of treatment will produce a feeling of exhilaration and renewed vigor in the patient more quickly than any regime based on strychnine or overfeeding.

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NASHVILLE JOURNAL — OF — MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

VOL. CVI.

SEPTEMBER, 1912.

No. 9.

Original Communications

HERNIAS OF THE UTERINE ADNEXÆ.

By AIME PAUL HEINECK, M.D.,
Surgeon to the Cook County Hospital, Chicago.

In the female, the frequency of hernias, and especially of hernias of the internal genitalia, has been and is still underestimated. Owing to the lack of study heretofore given to this clinical entity, hernias of the uterine adnexæ are often overlooked, not uncommonly misdiagnosed, and therefore subjected to injudicious treatment: harmful alike to the individual and to the hernial contents, prejudicial alike to the patient's general well-being and to her reproductive powers. Impressed by the clinical importance of the condition, and surprised at the insufficient consideration given to the subject in even the most modern gynecological and surgical text-books, I have collected the following data which may prove of service to some of my professional colleagues as well as to future investigators of the subject. Knowledge of the occurrence and familiarity with the symptomatology of a clinical condition lead to its more frequent and more timely recognition.

Soon after beginning the consideration of the subject, we became convinced that deductions and conclusions to be valuable, should be based solely upon the study of cases whose accuracy of diagnosis is self-evident. Therefore in the preparation of this paper we have only considered cases in which the hernial con-

tents were demonstrated at the dissecting, autopsy, or operating table.

We have conformed to the nomenclature in actual use. However, to better insure precision of classification and a more intelligent discussion of the subject, we define, at times, perhaps needlessly, the terms employed. The word *hernia* signifies the permanent or temporary protrusion of one or more viscera from their normal situation through a normal or abnormal opening in the walls of the cavity within which they are contained. It implies the existence of a hernial ring, of a hernial sac, of hernial sac contents and of a sac coverings. In the hernias discussed in this article, the protruding organ was always either an ovary, an oviduct, or Fallopian tube and an ovary. In some cases, as associated hernial contents, we find omentum, a segment of the alimentary canal, a part of the urinary bladder, a rudimentary uterine horn, or the entire uterus, be the latter organ rudimentary, infantile, or of normal development. The tube or ovary or both in part or in their entirety may be herniated. All the hernias herein considered are external hernias; that is, their outermost overlying saccular covering is skin, and each, after reaching a certain stage of development, gives rise to a more or less visible, more or less palpable external swelling in the inguinal, femoral, ventral, obturator or sciatic regions, depending upon the anatomical location of the hernia. Internal hernias, that is, hernias in which one or more loops of intestine find their way into pouches or recesses in the posterior peritoneal wall, and diaphragmatic hernias, be the latter true or false, congenital or acquired, constitute other chapters of surgery.

The escape of the uterine appendages from their normal situation may take place through any of the weak spots or openings of the lower abdominal or abdomino-pelvic cavities. A hernia originating either in the internal or in the external inguinal fossæ and escaping above Poupart's ligament is an inguinal hernia; if escaping beneath the same ligament, it emerges through the crural canal and the saphenous opening, it is a femoral hernia; if through the obturator canal, an obturator hernia; if along the course of the gluteal or sciatic nerves and vessels, emerging al-

most always above, very infrequently below the pyriformis muscle, very rarely through the lesser sacro-sciatic foramen, a gluteal hernia; if through an operative scar in the abdominal wall, a post-operative hernia.

Though sanctioned by long usage, the classifying of hernias into congenital and acquired is, at times, misleading. It is misleading. It is misleading because it is practically impossible to determine the congenital or acquired nature of many hernias. Furthermore, the term congenital hernia, as now used, does not imply in the female that the hernia was present at birth, as it is also applied to hernias whose post-natal development is due to predisposing conditions of congenital origin; developmental defects, persistence of transitory embryonal or fetal states which, owing to their non-disappearance with growth, permit the occurrence of outward visceral displacements. Some hernias are congenital in the truest sense of the word; they are complete at birth, hernia contents being then present. In most of the so-called congenital hernias, the sac only is existent at birth; in an acquired hernia, the sac is always of post-natal development, and in all but hernias *par glissement* is entirely derived from the parietal peritoneum. Congenital hernial sacs result from the want of closure of peritoneal processes, such as the *processus vaginalis peritonei* in the male, the canal of Nuck in the female, etc., normally present in the fetus. Congenital hernias may appear at any period of life.

Orifices for the transmission of vessels and ducts are normally present in the muscular and aponeurotic layers of the abdominal walls. An acquired hernia is formed by the gradual or sudden escape through these orifices, pathologically widened, of viscera normally contained within the abdominal cavity; the viscera in their passage through and beyond the abdominal wall create paths of escape for themselves by bulging and pushing forward the parietal peritoneum.

In many cases, the congenital or acquired nature of the hernia is either too vaguely stated or is left unmentioned. Femoral hernia seldom occurs before adult life.

Tubal, ovarian and tubo-ovarian hernias occur in the colored

and in the white race. Commonly, the condition is unilateral; infrequently, it is bilateral. When bilateral, the hernias may or may not be developed to the same degree on both sides. The bilaterality may date from birth or may be acquired. In the latter case, the hernias may from the first have been bilateral or an interval of time of shorter or greater length may have intervened between the appearance of the two hernias. Sir Broca's case, when patient was eight months old, the right inguinal hernia appeared, but the left inguinal hernia did not become manifest before the patient was four years of age. All the bilateral tubal, ovarian, or tubo-ovarian hernias recorded in the medical literature of the last twenty years are of the inguinal variety. This is in accord with a well-known fact that, in both sexes, double femoral hernias are less frequent than double inguinal hernias.

A tubal, an ovarian or a tubo-ovarian hernia may co-exist with one or more hernias of other organs. Multiple hernias are not infrequent, the hernias being either of the same or of different types, as two inguinal hernias or one inguinal and one femoral hernia on the same or on opposite sides of the body.

The hernias which we have under consideration may or may not be associated with non-development, malformation, or absence of the other internal or of some external genitalia. In Martin's (Kossmann) case, a hernia of the left tube and ovary, the uterus was displaced upwards, forwards and to the left by a cyst of the right ovary having the volume of a man's head.

In almost all the cases the operation performed was a herniotomy, and as herniotomy affords little opportunity for direct examination of the pelvic organs, the condition of the non-herniated genitalia was determined in only a few cases.

Hernia is a widespread disease. The relative incidence of hernias of the internal genitalia as to age corresponds to that of hernia in general. In our series, the youngest patient was four weeks old at time of operation. Nicoll operated successfully for ovarian hernia two infants, each one and a half months old. The oldest patient operated on was seventy-eight years old. She had a left tubal obturator hernia. Lickley reports a right tubo-ovarian obturator hernia observed in a dissecting room subject who

had died of general debility and hemiplegia at the age of eighty-seven years. In many cases, the age is not stated. The age given by most authors correspond to the age of the patient at the time of operation and not to the age at which the hernia first appeared.

The study of the reported cases demonstrates:

- (a) The frequency of hernias during the first year of life.
- (b) The rarity of the condition from the first to the fifteenth year of life.
- (c) The noticeable progressive increase in the number of hernias observed from the fifteenth year on, the maximal frequency being seen during the fourth decade of life.
- (d) After the fortieth year there is a decline of the number of hernias. They become relatively rare as the extremes of life are approached.

During the child-bearing period hernias of either or of both uterine appendages have been observed in nulliparæ, in primiparæ and in multiparæ.

ETIOLOGY.

The predisposing and existing causes of tubal, ovarian and tubo-ovarian hernias are shown by an analysis of the collected cases to be the same as those of other hernias in the female. The persistence of the canal of Nuck is an etiological factor of the greatest significance in the causation of inguinal hernias. The canal of Nuck, the homologous of the processus vaginalis peritonei in the male, is a peritoneal diverticulum accompanying and adhering to the round ligament, descending in some cases as far as the insertion of that ligament in the labium major. This peritoneal process, whose dates of origin and disappearance are not accurately known, is usually found completely obliterated at birth; it may close after birth; it may even persist throughout life. When the canal of Nuck is only partially or completely unobliterated, it forms a potential hernial sac, and is conceded to be the most important congenital predisposing cause to inguinal hernia formation. It is a matter of common knowledge that preformed sacs are not of infrequent occurrence in the inguinal region. They have been found in other hernial regions. A sudden or forcible

increase in intra-abdominal pressure, such as can be determined by muscular effort, by a misstep in an attempt to save one's self from falling, can lead to hernia formation by causing the irruption in a preformed sac of a tube, an ovary or a tube and ovary. As during infancy, the internal genitalia can neither be displaced by their physiological activity which is nil, nor by the development of pelvic tumors (rare during early childhood), nor by muscular effort, it follows that hernias of the uterine appendages, at that period of life, are due to such congenital anatomical defects as facilitate tubal, ovarian or tubo-ovarian displacement.

Though, as an etiological factor in the production of hernias, the existence of hereditary predisposition is denied by some authors. To us, the influence of heredity appears positive. Hernia being a malformation often due to developmental arrest, such as non- or incomplete obliteration of the processus vaginalis peritonei, non-obliteration of umbilical ring, etc., it is subject to hereditary transmission. It is reasonable to assume that like structural characteristics beget a like predisposition and a like resistance to hernia development. Among other etiological factors should be mentioned:

1. All conditions associated with increased mobility of the uterine appendages:

(a) Lengthening of the broad ligaments consecutive to repeated pregnancies.

(b) Pathological relaxation of the ligaments due to puerperal sub-involution.

(c) Abnormal length of the broad, ovarian and infundibulo-pelvic ligaments.

(d) Relaxation of the other tubal, ovarian and uterine ligaments.

2. All conditions that tend to increase the intra-abdominal pressure:

(a) By overcoming the resistance offered by one or another of the weak points of the abdominal wall.

(b) Occupations necessitating repeated muscular efforts associated with increased intra-abdominal tension, as the lifting or pushing of heavy weights, etc.

(c) Physiological or pathological states which distend the abdominal cavity, which stretch the abdominal parietes and widen the orifices normally present in the muscular and aponeurotic layers of the abdominal wall: enteroptosis, obesity, abdominal tumors, ascites, pregnancy, etc.

3. All conditions which weaken the abdominal wall.

(a) Acute or chronic diseases debilitating the organism.

(b) Obesity.

(c) Traumatism.

(d) Enteroceles, epiploceles and entero-epiploceles.

(e) Feeble development or atrophy of the aponeurosis of the transversalis muscle and of the conjoined tendon.

(f) A shortening of the round ligament of the hernial side.

HERNIAL SACS.

Congenital hernias have sacs of pre-natal formation. That the canal of Nuck remains patent in many cases long after birth, even in adult life, has been proven by a number of investigators. Acquired hernial sacs are formed of parietal peritoneum forced by intra-abdominal pressure through some congenital or acquired defect in the abdominal walls.

In the female the following anatomical characteristics are strongly suggestive of the congenital sacs: Great vascularity, absence of sub-serous fat, folds, valvular or diaphragmatic constrictions, cyst-formations, scar-like induration of the wall, etc. In congenital inguinal hernias, it is also noted that the round ligament is intimately adherent to the sac.

As we see, the sac results from the bulging outward of the parietal peritoneum without solution of continuity. It consists of a neck, body, and fundus. Of these three, the neck is the most important. It is through it that the general peritoneal cavity communicates with the hernial sac cavity. It may be the site of constriction. The fibrous envelope of the sac is due to the condensation of the fibrous layers which the hernia in developing pushes forward.

The internal surface of the sac, whether the latter be congenital or acquired, has all the peculiarities of serous membranes.

In the female, encysted inguinal hernias result from partial closure of the canal of Nuck, the peripheral portion of which is transformed into a cyst in which a developing hernia prolapses or from the sinking of a hernia in preëxisting hernial hydrocele.

There is really no sacless hernia; but the herniated viscus may be an organ only partially covered with peritoneum.

In sliding hernias, the anterior and lateral portions of the sac are, as in ordinary hernias, derived from the parietal peritoneum, while the remaining portion is formed by the anterior surface of the herniated cecum, sigmoid, bladder, or Fallopian tube.

Hernial sacs may be dome-shaped, cylindrical, digitiform, sacculated or irregular; may show constrictions with intervening dilated portions. Most femoral sacs are small and not infrequently are embedded in a mass of fat. The sac in recent hernias may be very thin. In children and in young infants, the sac is extremely thin.

HERNIAL FLUID.

The reporters not infrequently state that fluid of some nature or other was present in the hernial sac. The fluid may be serous, sanious, muco-purulent or fetid in character.

HERNIAL SAC—CONTENTS.

Tubal Hernias.

The tube, either in part or in its entirety, may be the sole content of the hernial sac. As associated hernial contents, a portion of the urinary bladder, normal intestine, gangrenous intestine and omentum were noted. The herniated tube may be normal and free; may be adherent to sac; may be strangulated; may show inflammatory lesions; may be cystic; may be the seat of a pyosalpinx.

Ovarian Hernias.

The ovary may be the only content of the hernial sac, or may be associated with a cystic parovarium, with omentum, with intestine or with a rudimentary uterus. The herniated ovary is reported as being in some cases normal, in others enlarged to

twice its normal size, infiltrated with blood, the seat of a large hematoma, adherent to sac, cystic, to have presented areas of suppuration, to have shown gangrenous changes.

Tubo-Ovarian Hernias.

Hernias of the tube and ovary constitute the largest number of hernias of the uterine appendages. As associated hernial contents may be mentioned: urinary bladder, Meckel's diverticulum, the appendix vermiformis, omentum, intestine, and the uterus.

We know of only two cases in which gestation occurred in an inguinal hernial sac; both were tubal pregnancies.

The herniated organs may be normal, may show slight or marked pathological changes. The displacement of a tube or of an ovary into a hernial sac is unfavorable to its anatomical and functional integrity. In a hernial sac, these organs are exposed to repeated slight traumatisms and to circulatory disturbances. The herniated ovary frequently undergoes cystic changes; may show atrophy; may show enlargement; may be undersized.

The herniated tube may be the seat of suppurative salpingitis, of abscess, of tuberculosis; may be adherent to sac by an inflammatory band.

We must not forget to state that a tube and ovary present in a hernial sac do not always have the same reciprocal relation that they have in the abdominal cavity, and that the pathological changes which they show may antedate their displacement into a hernial sac.

Reducible Hernias.

In reducible hernias, and, at first, practically all hernias are reducible, the hernial contents either return spontaneously into the abdominal cavity when the patient assumes the recumbent posture, or they can be manipulated back, with more or less difficulty, but without a cutting operation, into the cavity from which they escaped. Even in reducible hernias, the sac early contracts adhesions to neighboring tissues and becomes irreducible. The terms reducibility, irreducibility, torsion and strangulation, have reference only to the hernial contents and not to the sac.

Reposition, spontaneous or manual, may be temporary, may be permanent. Many reducible hernias reappear as soon as the standing posture is assumed; others, to reprotude, require more or less effort on the part of the patient.

Irreducible Hernias.

When the contents of a hernial sac can not in their entirety be manipulated back into the abdominal cavity, the hernia is said to be irreducible, provided that there is not any or but a very slight interference with the blood supply of the herniated organ or organs, and that there is no disturbance of function. If irreducibility, and both, functional and circulatory disturbances are present, the hernia is designated as strangulated. Irreducibility, partial or complete, predispose to complications of a serious nature—inflammation, incarceration, strangulation and torsion.

The irreducibility of hernias is dependent upon one or more of the following factors:

(a) Difficulties incident to manipulating a small movable body, such as the ovary, through a small opening.

(b) Relative narrowness of the hernial canal—femoral, inguinal, etc.

(c) Sudden increase in size of hernia resulting from some unusual muscular effort.

(d) Changes in the hernial contents: increase in bulk from deposit of fat, from cyst formation in mesentery, in omentum, from inflammatory or neoplastic changes.

(e) Adhesions of inflammatory origin:

1. Between sac and contents;
2. Between the different contents.

(f) Large volume of the hernia.

(g) Sliding hernias (*hernies par glissement*).

The irreducibility of a hernia of the uterine appendages is due in some cases to the presence as associated hernial contents of the urinary bladder, of the cecum, or of the sigmoid. In other cases, the irreducibility is due to the fact that the layers of the broad ligament, as they leave the Fallopian tube, enter into the formation of the hernial sac.

Strangulated Hernias.

All strangulated hernias are irreducible. In addition to irreducibility, they present a constriction of the hernial contents of such a degree as to seriously interfere with the circulation of the blood in the herniated organ or organs. "If the pedicle of a tumor is tied off, or if a finger is surrounded tightly by a string, the parts distal to the ligature do not become inflamed; stasis and gangrene result" (Alberts). The same primary changes occur in the contents of a strangulated hernia; the inflammatory changes are secondary to the circulatory disturbances. There is interference first with the venous circulation, then with the arterial. As a result of this interference with the circulation, we have a serous exudate the amount of which depends upon the degree and duration of the strangulation, and also upon the extent of the secreting surface. The sequence of events is as follows: Congestion, stasis, serous exudation, then inflammatory phenomena and gangrene. Strangulation of a herniated tube or ovary is not as dangerous a complication as strangulation of a herniated loop of intestine.

Strangulated inguinal hernias may be congenital or acquired. Strangulation may occur at any age, irrespective of type of hernia or of hernial contents.

As hernial contents can be mentioned the following organs: Fallopian tube, ovary, tube and ovary, tube and a portion of the urinary bladder, tube and a loop of small intestine, ovary and intestine, tube, ovary, intestine and omentum, uterus and adnexæ of one side, loop of intestine, uterus and left adnexa.

The symptoms given by the strangulated inguinal hernias are those of inflamed hernias. Symptoms of intestinal obstruction may also be present.

TORSION OF THE PEDICLE.

This complication, peculiar to ovarian and to tubo-ovarian hernias, is not of unusual occurrence. As far as we have been able to determine, torsion of the pedicle has been observed only in irreducible congenital hernias of the inguinal type.

The two youngest patients were four and eleven weeks old respectively. The oldest, a poorly nourished child, was fourteen months old. All the other patients were less than one year old. The right and left side are involved with about the same frequency. The occurrence of this accident is favored by the mobility of the ovary and the slenderness, at this period of life, of the pedicle of the herniated organ or organs.

The pedicle, usually composed of the Fallopian tube, broad ligament and contained vessels, may have made a half-turn upon itself; may be twisted twice, thrice or several times upon its axis. The pedicle may be twisted in any part of its course.

If unrelieved, torsion of the pedicle determines in the hernial contents anatomical changes similar to those caused by strangulation. The impeded return of blood in the veins leads to congestion and swelling of the organ or organs below the twist. There are noticed in the hernial contents the following circulatory disturbances: Congestion, stasis, thrombosis, vascular rupture (ovary seat of large hematoma) and interstitial hemorrhages. The interstitial hemorrhages and the serous transudates lead to tissue dissociation.

In torsion of the pedicle, the amount, odor and color of the hernial fluid depends upon the tightness and duration of the twist and upon the extent of the gangrenous changes. The fluid present in the hernial sac may be serous, may be blood-stained, dark colored, reddish brown.

Torsion of the pedicle gives rise to symptoms somewhat analogous to those of strangulated intestinal or omental hernias. In fact, the condition has frequently been diagnosed a strangulated intestinal hernia.

POST-OPERATIVE VENTRAL HERNIAS OR HERNIAS IN ABDOMINAL SCARS.

The protrusion of parietal peritoneum with stretching of the cicatrix over it, may occur after an operative or other penetrating wound of the abdominal wall, except those of very small dimensions. Though these hernias may occur in any part of the ab-

dominal wall, they are located almost always either in the median line or in the region of the appendix. Owing to the employment of improved operative technique, and to the more rigid observance of the requirements of surgical sepsis, post-operative hernias are decreasing in frequency.

There are two types: In one, there is a uniform distension of the cicatricial tissue producing a condition somewhat analogous to separation of the recti muscles; in the other, the hernia is due to the giving way of weaker portions of the scar.

The main predisposing etiological factors of post-operative hernias are:

1. Long incisions.
2. Faulty closure of abdominal wounds.
3. Operations for suppurative processes which of themselves require, for healing, that the abdominal wound be maintained open for a considerable period of time.
4. Drainage.
5. Disturbed wound healing—imperfect asepsis-suppurative.
6. Failure to wear for some months after recovery from operation a well-fitting abdominal binder.
7. Too early pressure upon the scar.
8. Pregnancy.

The only ventral hernia of the uterine appendages which we could find is a tubo-ovarian hernia in an abdominal scar resulting from the opening and prolonged drainage—ten years previously, of an appendiceal abscess. The scar was about six inches in length. Cullen, to cure this case, resected the entire cicatrix, loosened the adhesions of the omentum to the ovary, then removed the herniated ovary and hydro-salpinx, and followed this by closure of the abdominal wound without drainage. A satisfactory recovery was obtained. The sac was incomplete for a considerable distance. The ovary lay directly beneath the skin.

(To be concluded next month.)

BUSINESS IN MEDICINE.

By W. T. BRIGGS, M.D., Nashville, Tenn.

We have just read an editorial in the *Medical Brief* under this same title. For the most part we agree with the writer of this article, but think he makes a mistake in stating that business and medicine can not go together. According to this writer, when one enters upon the practice of medicine, finances must become a secondary consideration—the doctor must not allow his thoughts to dwell upon the subject of money but concentrate his whole mind on his patients and their ills. Theoretically, this is true. It is a beautiful thought indeed to look upon your confreres and yourself as the only human beings who have succeeded in overcoming, smothering, this first law of nature—self-preservation. But do your confreres live up to this ideal? Do you live up to such a lofty ideal? We think not. Money may not count as much with physicians as with others, but so long as our bread is purchased with money it must and it does count.

In these modern times, self-preservation depends not on physical power, but upon financial power, and he who allows his exchequer to slowly but surely become depleted is as sure to suffer defeat and be marked a failure, as the ancient chief whose powers were failing was sure to be supplanted by a younger, stronger man. To the young doctor especially the financial side of medicine is very important and many a good man has had to abandon medicine for business, not because he found he had chosen the wrong profession, but because necessity forced him into some other, more lucrative business. The young doctor often makes enough to tide him over the first few years of bitter struggle, but since he can not collect what he makes the only recourse is—another business.

Medicine and business methods can go together and would go together if the profession would unite in one strong effort to improve its financial conditions. However, for some unexplained reason, doctors can agree on very few subjects, and so far they have not publicly agreed on prices and collections. Even in the

profession itself there is little or no agreement on prices. Naturally, there can be no fixed price for any medical or surgical service, not even for visits, but there could be a fixed lower limit with the understanding that the bill should always be rendered for that amount. Let us say, for instance, the profession in our county has agreed that any abdominal section is worth at least \$100.00, \$125.00, \$150.00. Then to those who can ill afford to pay so much, yet insist on not going to the hospital, the surgeon sends his bill of \$100.00. In case they can not pay \$100.00, they pay what they can and the doctor credits them with the remainder. This at least does not belittle the skill required for the operation nor detract from the respect owing the profession. In the same way all major operations and many minor ones should have fee agreed on by the county society, because each county should have its own scale of prices, or at least each State. Likewise the minimum fee could be fixed for visits, office consultations, dressings, medical and surgical consultations, etc.

These fees should be published at least semi-annually, not only in the medical journals, but also in the lay press. There would be nothing new in such an agreement except its publicity, because at present it is the custom to make fixed charges for visits, night visits, medical and surgical consultations, circumcisions, obstetrical, gonorrheal, syphilitic cases, etc. However, since these charges are not published and some doctors are always under charging, the tendency is for fees to constantly decrease in spite of the fact that medical education is becoming more and more expensive. Consequently doctors' fees have not advanced along with the advance in wages, food prices, clothing, etc., but have constantly decreased. Nor are doctors paid more promptly now than years ago—if anything they are paid less promptly.

If these minimum prices were agreed on and published it would be a boon to all. It would do more toward stopping fee splitting than all the legislation of the American Medical Association; it would prevent those who can afford the fee from Jewing the surgeon down until he finally in disgust refuses the case or takes it simply because he wants to do the operation; it would prevent the honest poor from assuming a debt they can not pay, and final-

ly it would keep the profession unsullied by the practices of those who are disgracing it, detracting from the respect owing it, by charging fees perhaps commensurate with their skill, but not with the skill of others doing the same work.

At present charges are guessed at, and the young doctor often makes a ridiculously low charge or one just as ridiculous because it is too high. If he asks older doctors he is often advised to charge what he can get.

That "each case is a law unto itself" can not be denied. However, it is equally true that all cases of the same disease are somewhat similar. As the disease varied, causing the attendant more trouble than usual, he could vary his fee, and of course every doctor should have the right to charge as much as he desires for any case, and it should be published along with the proposed list of fees that those who can afford it are expected to pay more than the minimum fee. People know now that such is the case, so what is the difference? Perhaps it is argued that every doctor has the right to fix his own fee. He should have this right only in so far as his fees do not detract from the respect owing to the profession. If a physician thinks his visits worth only a dollar, his obstetrical cases \$10.00 to \$15.00, his laparotomies only \$25.00 to \$50.00, then the laity would make him think differently by letting him know his fees are too low. The fee cutter often lowers not only his own fees, but the fees throughout his entire field of practice.

What we need is publicity. The layman should have some way of knowing he is not being robbed when the physician's fee is larger than he expected, and publicity is the only way of letting the layman know. When the physician or surgeon does some service skillfully and rapidly the layman is apt to think it easy for anybody to do and so always expects a small charge, not knowing that what was done required years of study or work.

The layman can never know what a medical or surgical fee should be, therefore a body of men who do know should fix fees in accordance with the skill and study required. Surely there can be nothing unethical in having our mode of charging made public.

Further, we believe the profession in each county should choose from the members of the county society a financial committee. To this financial committee all doctors in the county should send in annually a list of "dead beats." By this term I do not mean the worthy poor, but those who can, but do not pay. And annually this finance committee should have an alphabetical list of the "dead beats" published and mailed to members of the society. This would at least give every doctor a chance to know how much pay to expect and then he could act as his conscience dictated. We all have charity patients and the doctor who has no time for this unfortunate class should give up practice and join a collecting agency; but we all likewise have some of the "dead beat" class, and it's this class that such a procedure as that outlined above would soon eliminate. No doctor should refuse an emergency call, whether it is to the rich, poor, or the above-mentioned "dead beat" class. However, every doctor has the right to dismiss himself from a case after he has rendered the first aid to the injured.

The doctor is not, strictly speaking, a business man, but in so far as he depends on his practice for a livelihood he is engaged in a business. Since such is the case there is no need in our trying to hide our cash books under a cover of altruism, declaring "money is no object." That only adds hypocrisy.

If money is really no object, then let us all agree to do our work gratis, depend on some other source of income and cure disease not for money but only for gratitude. However, if we are to combine medicine and business, which we all do when we render a bill, then let us do so in a business like way and receive for our services proper fees and for ourselves due respect.

The fewer worries the doctor has in regard to finances the more will he be fitted to attend to the scientific and humanitarian side of his work. Therefore, we argue that by inculcating into the profession as a whole, business methods, we remove financial difficulties from the path of the individual practitioner and so enable him to devote more time and study to the practice of medicine.

Proceedings of Societies

AMERICAN PROCTOLOGIC SOCIETY.

Fourteenth Annual Meeting, Held at Atlantic City, N. J.,
June 3 and 4, 1912.

(Concluded from last issue.)

MULTIPLE ADENOMATA OF THE RECTUM.

A report of a Case with Symptomatic Relief by Simple Remedies.
By E. H. Terrell, M.D., of Richmond, Va.

This article was a report of a case of multiple adenomata of the rectum and sigmoid, in a patient 41 years of age, who had been suffering for the past five years. He had frequent stools with mucus, some blood and a great deal of tenesmus. He was having from eight to ten stools daily. He suffered considerable pain throughout the abdomen. Examination showed numerous small tumors scattered through the rectum and sigmoid. Microscopic examination showed these growths to be adenomatus. The bowel was intensely inflamed and contained many ulcers. Under irrigation of the bowel with boric acid and the administration by mouth of castor oil and aromatic syrup of rhubarb, improvement was almost immediate. In three and a half months the patient had gained seven and a half pounds, and was comparatively comfortable. The tumors were reduced in size and the ulcers gradually disappeared. While the adenomatas are still present the patient is symptomatically cured.

Dr. Terrell emphasized the value of the administration of equal parts of rhubarb and castor oil, and thinks that in simple ulceration of the rectum, this treatment alone is almost a specific. He calls attention to many reports of cases in which adenomatas of the rectum are supposed to disappear, and points out that this condition must be merely a hyperplasia with inflammation, and,

not true tumors, for the latter are permanent. As regards the predisposition of adenomata to become cancerous, he called attention to the fact that these tumors are benign, and are consequently composed of mature tissue, so they can not themselves become immature, which is malignancy. Instead of a malignant degeneration, it is likely that matrices of immature tissue have also been deposited where so many matrices of mature tissue are found, and the growth of the adenomata, with the accompanying inflammation and ulceration, stimulates these immature matrices to develop into cancer; or, else, immature matrices are formed from the ulcers, just as they develop from ulcers, in cancer of the stomach. The simple treatment which he proposed not only relieves the patient's symptoms, but by lessening the inflammation and curing the ulcers, it also decreases the chances for subsequent malignancy.

PIGMENTATION OF THE RECTUM AND SIGMOID.

By Jerome M. Lynch, M.D., of New York City, N. Y.

The paper was based on six cases which came under the observation of Dr. Tuttle and himself. He divided pigmentation into exogenous and endogenous.

Endogenous—Hemochromatosis, Pseudomelosis, Melanosis.

Exogenous—Pigmentation due to Chemicals or Metallic Pigmentation.

He proceeded to discuss the origin of pigment, and considered Pick's theory concerning the origin of melanosis in pigmentation of the large bowel, particularly interesting.

It is as follows:

That the connective tissue cells possess an enzyme tyrosinase, which converts aromatic bodies into melanin.

After having reviewed the subject of pigmentation, he reached the following conclusions:

That hemochromatosis is of bacterial origin; that the extent of the disease is dependent upon the severity of the infection; that the probable source of infection is the intestinal tract, possibly

starting as an intestinal putrefaction that this intestinal putrefaction lowers the vitality of the tissues, and thereby the cells of the mucous membrane lose their protective properties, consequently bacteria find ready access to the portal circulation. As a result of this the chromogenic function of the liver is interfered with, consequently the liver becomes surfeited with pigment, and is not capable of abstracting the iron from the hemoglobin, with the result that an excessive amount of pigment is circulating in the blood. That the cells of the intestine probably have a selective action for these pigments, and as a consequence they are deposited in the tissue. That local hemochromatosis may be due to repeated local hemorrhages, followed by infection, and that as a result of this infection the bacteria cause a hemolysis of the blood, forming pigment which resembles hemosiderin, hemotoiden and hemofucin. That these pigments may, or may not, give a reaction for iron.

So little is known about the structural products of melanin or melanoids, that it is difficult to give the origin of those bodies. Undoubtedly there are several distinct melanins, and their origins must also be distinct. The ferruginous melanins should be considered as originating from the blood pigment until further research proves the contrary. Most melanins yield endol, scatol and pyrol. It has been proved that the enzyme tyrosinase is present in the tissues and further that this enzyme is capable of converting aromatic bodies into melanin.

That Pick's theory is ingenious and worthy of consideration, we admit; but there are points that are hard to reconcile with our present conception of cellular activity.

It is hard to understand why he should attribute to connective tissue cells a highly specialized function; that this is directly opposed to all our preconceived notions of this cell, which heretofore has been supposed to have only one function—that of binding other tissues together with an enzyme of its own nourishment.

It is a well known fact that the cells of the mucous membrane have the power of neutralizing poisons and converting them into insoluble compounds. In the case of mercury and lead they are

converted into sulphides, and as a result of this change, blackening of the tissues, somewhat resembling melanin, takes place.

Drs. Tuttle and Lynch believe that the cases reported by the English observers were as stated, and should not have been included in Pick's series. Further, that as a result of the action of sulphate of hydrogen on the iron pigments, an insoluble sulphide of iron is formed, blackening of the tissues takes place. This is a separate and distinct form of pigmentation, and should not be confounded with melanosis.

OBSERVATIONS UPON THE RELATIONSHIP OF TUBERCULOSIS
TO PERI-RECTAL SUPPURATIONS.

By Collier F. Martin, M.D., of Philadelphia, Pa.

The author has found pulmonary tuberculosis so frequently associated with his cases of peri-rectal suppuration that he determined to report a consecutive series of cases, with findings.

The report comprises 376 consecutive cases, 75% being males, and ranging in age from 7 months to 87 years. The majority of these cases (322) occurred in the most active period of life, from 20 to 60 years.

He divided his cases into four major groups; the actively tubercular (144 cases), the chronically tubercular (68 cases), the phthisenoid (20 cases), and those patients in apparently good health (55 cases). This would indicate that at least 212 cases or 67% were cases of known tuberculosis.

There were 309 operations performed on 306 patients, under various anæsthetics; spinal anæsthesia 145 times, ether 54 times, and local and other anæsthetics on the remaining. He chose spinal anæsthesia where no other preference was expressed by the patient or the attending physician, on account of the associated tuberculosis.

Following these cases for the past four years he has traced thirty-seven deaths, of which thirty-four died of active tuberculosis or its complications.

The abscesses or fistulæ in most of these cases could not be

classified, from their appearance, as being locally tuberculous. Where the tubercle bacillus was easily recovered from the tissues or discharges, there was usually a very active pulmonary infection present.

The writer believes that the usual explanation of the association of pulmonary tuberculosis with rectal suppurations, lies in the fact that any pulmonary lesion, however small or inactive, may so alter the patient's vital processes and so lower the opsonic index, as to make him particularly susceptible to pyogenic invasion. The same may be said of pyogenic infections in general, but the peculiar anatomic conditions existing in the rectum and its very active physiologic function, makes this a fertile region for external trauma with subsequent inflammation and infection.

Traumatism is considered to be the chief active factor in impairing the integrity of the tissues.

The writer emphasized the fact that a careful lung examination should be made in all cases of peri-rectal suppuration. He also made a strong plea for a careful and extended supervision of the patient's general health for a long period after all surgical treatment had been discontinued.

The vital consideration in these cases is not the question as to whether or not the local lesion is tuberculous, but has to do with the presence or absence of active or latent tuberculosis in the patient, and his chances of having good general health after surgical intervention.

ANO-RENAL DISEASE DUE TO VENEREAL INFECTION.

By Jas. A. McVeigh, M.D., of Detroit, Mich.

Venereal disease is an important factor in the etiology of disease in all parts of the human system. Regional relationship of genital organs to anus and rectum render the latter especially prone to this kind of infection. Venereal disease of anus and rectum either direct, through practice of vicious habits, or indirect, or accidental, through extension of infection to these parts from other sources. Less direct infection of this nature in this

than in foreign countries. Gonorrhoea, chancroid and syphilis, the principal venereal factors in ano-rectal disease. Description of symptoms, diagnosis and treatment of these conditions when appearing in disease of the rectum and anus. Report of a case.

FURTHER OBSERVATIONS ON PRURITUS ANI: ITS PROBABLE ETIO-
LOGIC FACTOR, BASED UPON ORIGINAL RESEARCH.

By Dwight H. Murray, M.D., Syracuse, N. Y.

This paper was a continuation of the work that he has been engaged in for the past two years and which he presented to the American Proctologic Society at the Los Angeles meeting in 1911.

From his experiences, since discovering that a skin infection is the important factor in pruritus ani, he believes that we are now in a position to state that there may be two varieties of pruritus ani; one that may be coincident with some of the diseases of the rectum and in which the skin infection is not present. He designates this form as pruritus ani simplex; the variety, which is chronic in its character, and in which the skin infection is present, he designates as coccigenous pruritus ani.

He states that he is continually seeing patients who have all varieties of rectal diseases, including chronic diarrhea and proctitis, in many of which there is a leakage of moisture upon the anal skin; in very few of these cases does he find pruritus ani, and he believes that when it is present it is coincident rather than having been caused by these discharges occurring in various diseases.

He gives a resume of an examination of 900 consecutive cases, in which he finds 490 cases of constipation, 369 of hemorrhoids, and 94 of pruritus ani. Of the 94 cases, which gave a history of pruritus ani, he finds that 5 per cent of the 900 cases examined who had pruritus ani were constipated; 2.3 per cent had hemorrhoids; 1.2 per cent had some form of anal growth; 2.2 per cent had ulceration; 2.5 per cent diseased crypts; 1.3 per cent hypertrophied papillæ; .03 per cent had polypi; .03 per cent had fistulæ. He believes that the relatively small percentage of each of

these conditions that were present in the pruritus ani cases show that they were coincidental when present, and could not be classed as causes of pruritus ani.

Thirty-two of these 94 pruritus cases have been examined bacteriologically by him and all of them showed streptococcic skin infection as the predominating condition.

He believes that the excess moisture and the infiltrated condition of the skin in these cases is due to the low grade inflammation caused by skin infection and is not the result of moisture coming from the inside of the anal canal.

He presented photographs of petri-plates of a typical case, showing the immense numbers of streptococci at the time of the first examination; another photograph of the same case, showing that streptococci were not present in the culture taken from the anal canal, and another photograph of a petri-plate, of the same case, after four months' treatment (one month after itching had ceased), in which last photograph no streptococci were present.

He gives a report of his technic in greater detail than in last year's paper, because he has found that the last year's report was not understood by some physicians who had employed his method.

From some reports received he believes that stock vaccines will not give good results because they are made of a different branch of the streptococcic family than the one causing pruritus ani.

He gives detailed reports of the cases treated, both of the first and second series, showing very marked improvement in all of the cases and cures, so far as present conditions are concerned, of others.

He presented a series of twelve control cases, having a variety of rectal diseases, that are usually given in text-books as causes of pruritus ani, none of which had the disease nor did they show a skin infection.

He said that the conclusions of the first year's work still hold true, and he gave the conclusions of his second year's work as follows:

First.—It is shown by the nine hundred consecutive cases of rectal diseases that constipation and hemorrhoids, or any lesion

are coincidental or may be predisposing, but not the exciting cause of pruritus ani.

Second.—Even when there is a discharge of pus or other moisture on the skin about the anus it is not the actual cause of pruritus ani, unless there is a streptococcic or other infection of the skin. They may exist together, but are then only a coincidence.

Third.—All investigators, in making cultures, should use in addition to the hard media and Gordon's series of carbo-hydrates, if they wish to differentiate the streptococci and other bacteria.

Fourth.—Avoid excessive reaction.

5th—Use small initial doses.

Sixth—Give subsequent injections only after the previous reaction has completely subsided.

Seventh.—He suggests the following change in the nomenclature of pruritus ani, by recognizing two varieties: Pruritus ani simplex, and pruritus ani coccigenous.

COLONIC DILATATION (CONGENITAL AND ACQUIRED) AS A FACTOR IN
CHRONIC INTESTINAL OBSTRUCTION (OBSTIPATION).

By Samuel G. Gant, M.D., of New York City, N. Y.

The author stated that his experience warrants the belief that both acquired and congenital (Hirschsprung's) dilatation of the colon is fairly common, and that they respond satisfactorily to treatment (usually surgical). He said that non-congenital dilatation of the bowel might result from paresis, gormandizing, digestive disturbances or chronic obstruction, however caused, and when present, leads to constipation or chronic intestinal obstruction, however caused, and when present, leads to constipation, fecal impaction, distension of the bowel, angulation, twisting and ptosis of the colon. He called attention to the fact that this class of patients suffered much less from intestinal auto-intoxication than persons afflicted with acute constipation. In his cases, the colon completely filled the abdomen, measured from to many times its normal size, was considerably thickened, characterized by dilated blood vessels, and closely resembled an enormously hyper-

trophied stomach—for which it was mistaken in two instances. He mentioned having personally observed seven cases of Hirschsprung's disease and a still greater number of acquired dilatation, wherein the patients had an evacuation every two or three weeks, following purgation and frequent enemata; except in two instances, that of a young boy, who moved his bowels only once in two months, and of a young woman, who succeeded in accomplishing this but four times yearly. He said the chief manifestations of the condition were those of chronic constipation and fecal impaction, plus mal-nutrition, abdominal distension, pot-belly, extraordinary length of time between the movements and very large amount of feces discharged when an evacuation occurred, and that the diagnosis is fairly easy in the presence of the above symptom complex, because, with the aid of inflation and palpation or the assistance of the X-Ray, the size and position of the colon can be defined.

The writer maintained that temporary improvement occasionally follows medication and physical measures, which strengthen the bowel or minimize the effects of auto-intoxication consequent upon fecal retention, and that patients may for weeks or years be kept fairly comfortable when given close attention and the bowel is kept open with lubricating oils, laxatives and frequent high enemata, but that a cure is not possible except through one of the following surgical measures, viz.:

- | | |
|------------------|-------------------------|
| 1. Coloplication | 4. Intestinal exclusion |
| 2. Colopexy | 5. Colostomy |
| 3. Resection | 6. Tapping |

He found coloplication effective in both congenital and acquired dilatation, without bowel displacement. Colopexy proved satisfactory where there was ptosis with moderate dilatation, but, in aggravated cases, where the bowel was both enormously dilated and markedly ptotic, he advised coloplication and colopexy, using the infolding sutures for suspensory purposes.

He advised resection of all or part of the colon where it was irretrievably large, displaced or bound down by adhesions, and

reported a case where the sigmoid flexure, descending colon and left half of the transverse colon were excised.

Exclusion had proven satisfactory, and he reported five cases treated by dividing the ileum near the cecum and completing the exclusion by ileo-sigmoidostomy.

Colostomy was looked upon with ill-favor, because patients strenuously object to an artificial anus, and, a secondary and dangerous operation is required to re-establish continuity of the intestines.

Tapping, he said, deserved no consideration, because it is unscientific, dangerous and ineffective.

In closing, Dr. Gant said that he frequently combined the above operations with appendicostomy or cecostomy, so that through and through irrigation could be immediately established and the period of convalescence shortened. He also stated that colonic exclusion and colostomy were considerably less dangerous than resection, and were usually effective, since the bowel rapidly contracts after their establishment.

ACUTE POST-OPERATIVE INTESTINAL PARESIS.

By J. A. MacMillan, M.D., of Detroit, Mich.

1. *Definition*.—A paralysis of a portion of the intestines which suddenly dilates and becomes the receptacle for gas and fecal material.

2. *Etiology*.—Not known, but probably due to sepsis, trauma, etc.

3. The lesion is probably in the sympathetic nervous system.

4. The treatment consists of gastric lavage, enemata, and enterostomy.

5. Precautions attending a secondary operation.

PROPHYLAXIS AND TREATMENT OF POST-OPERATIVE
RETENTION OF THE URINE.

By Frank C. Yeomans, M.D., of New York City, N. Y.

Ascertain and correct, if possible, lesions of the urethra and bladder in advance of operation.

Physiology of urination. Factors that interfere with it after operation.

Prophylaxis—Urinary antiseptics and posture.

Treatment.—Suggestion, local applications, medicine, standing. Aseptic catheterization.

INTRA-RECTAL RUPTURE OF SUPPURATING SINUS FROM
HIP JOINT DISEASE.

By Ralph W. Jackson, M.D., of Fall River, Mass.

To meet the difficult problems presented by an unusual case, involving the rupture, internally, into the rectum, and externally, near the anus, of a sinus from a tubercular hip, the writer sought, by radiographic study, research of literature, and correspondence with proctologic and orthopedic authorities, information as to frequency, pathology and operative possibilities, of such cases; and with the following conclusions:

1. That intra-anal or rectal rupture of a coxitic sinus, occurs rarely but not with extreme infrequency.

2. That such opening, involves probably considerable mixed infection of the joint beyond what would occur if the opening were external.

3. That likewise tubercular infection of the rectum might arise.

4. That intra-anal opening is quite easily treated and much of the mutual risk of infection removed.

5. That intra-rectal opening is in most cases (unless the sinus approaches from low down) too high to turn aside in any way and give an external discharge and consequently the risk must continue.

6. That operating for such purpose is likely to create at once a complete rectal fistula where none existed before, because of the surgical difficulties in the way of securing permanent closure of the internal opening.

7. That it is a very rare and most unfortunate occurrence for such an abscess to point both externally and internally; an external incision should be made, if sure that internal rupture has not occurred; but avoided, if possible, if it has occurred, because of the fistula thereby created.

8. That whatever the etiology, such a fistula is a particularly troublesome one, and the wisdom of trying to better it surgically is fairly debatable ground.

PRELIMINARY REPORT OF TWO CASES.

(a) Keloidal Tuberculoma.

(b) Fibromatous Keloid.

By Alois B. Graham, A.M., M.D., of Indianapolis, Ind.

The writer presented a brief preliminary report of two exceedingly rare rectal cases. Both of the cases are of interest in that they emphasize the following points:

1. A benign neoplasm, involving the peri-anal, peri-rectal and surrounding structures, may be the end-result of an inflammation of these structures.

2. An inflammation of these structures is due, in a large proportion of cases, to extension from an anal or rectal inflammation.

3. A benign neoplasm may produce a marked deformity of the structures which it involves. (The writer showed photographs of his two cases.)

4. A careful pathologic study is essential for making a correct diagnosis of the neoplasm.

5. A correct diagnosis of the neoplasm can be made, and yet, its etiology remains vague.

A history of the cases was given with a description of the operations performed. The pathological report shows one case to be Keloidal Tuberculoma; the other, Fibromatous Keloid. The

first case insisted upon leaving the hospital and was discharged as improved. The second case, that of Fibromatous Keloid, is still under the observation of the writer. Hence the preliminary report.

In conclusion, the writer stated his object for reporting these two cases. He is firm in his belief that an anal or rectal inflammation was the origin of the diseased conditions presented by these patients. Both cases, therefore, emphasize the necessity for and the importance of rectal examinations. It matters not how slight the ailment may be, a careful inspection of the anus and rectum should be made. If such a rule were followed by every physician and surgeon, such case reports would not be possible.

SOME PRACTICAL POINTS GLEANED FROM THE OBSERVATIONS OF A PROCTOLOGIST.

By Samuel T. Earle, M.D., of Baltimore, Md.

Dr. Earle reported a case of primary tubercular ulceration of the right buttocks, which was not connected with the rectum by a fistulous tract. In this respect it differed from the one reported by him, in his work, on "Diseases of the Anus, Rectum and Sigmoid," Figure 62, page 201. It was excised by the thermo-cautery knife, after which, it healed very promptly.

Dr. Earle also reported a very aggravated case of pruritus ani, which had resisted local applications, autogenous vaccines and treatment by the X-Ray. Under local anesthesia he found an ulcer over the posterior commissure just above the internal sphincter, which connected on each side with numerous sub-mucous superficial fistulæ, which enveloped the entire anal margin and connected with each crypt of Morgagni. The ulcer was incised, the scar tissue, at its base removed, and, the fistulous tracts were all opened up. There was only an occasional twings of itching following the operation, and he made a speedy recovery.

THE SUBNORMAL COLONIC FUNCTION AS A DIATHESIS.

By J. Coles Brick, M.D., of Philadelphia, Pa.

The writer was led to investigate the causes of a persistent case of constipation, which had existed since childhood, and which was an average duration of seven days, in a young woman of 18, who was in seemingly good health, but whose father having had the same condition and who had subsequently developed a case of chronic arthritis deformans. The young woman had been treated by many doctors and by many methods, but all without any more than temporary success.

Resort was finally made to X-ray examination after giving bismuth meal. The plates showed that at two points, viz.: the cecum and the rectum, the colonic contents remained for three days, and operative measures were decided on. No abnormality was found except an old and thickened appendix, containing three concretions, and the tip being adherent to the ovary. As there were some moderate seized hemorrhoids present, these were removed at the same time as the appendix, and the patient made a good recovery. The X-ray plate showed a very moderate degree of visceroptosis, and a "Storm" belt was ordered. The patient has had a regular bowel movement daily, with the use of a mild laxative, which it had been impossible to produce at any previous time.

Examination of the X-ray plates showed a bilateral calcification of the costal cartilages, which the writer thought was an early symptom of arthritis deformans, and after discussing the various theories of the cause of the disease, accepts the theory that it is a toxic trophoneurosis affecting the cerebro-spinal nerves, with its infectious focus in the gastro-intestinal canal.

The essayist believes that all cases of persistent constipation should be examined by all the means at our command, and finally, not only by the administration of bismuth by the mouth, but by injection, with X-ray examination. Conditions requiring operative interference will frequently be found by this means, and corrected surgically.

Arthritis deformans is a most ancient disease, and evidences of many cases are shown to have existed before the pyramids were built, and that it is not only possible but probable that the infection comes from the intestinal tract, and that if the cause is removed early before the destructive changes have occurred these cases can be cured, and even the advanced cases have their progress arrested.

THE THREE-STEP OPERATION IN TUMORS OF THE SIGMOID
AND COLON.

By James P. Tuttle, A.M., M.D., of New York City, N. Y.

Dr. Tuttle described the operation as follows: Incision is made in the outer border of the left rectus. Tumor is brought out on the abdominal wall. Peritoneal layers of the meso-sigmoid are incised well above and below the tumor, and stripped back so as to expose the blood-vessels, fat, and glands, which may be in the meso-sigmoid; the latter are stripped toward the intestine until the blood vessels are bare and the supply to the bowel is easily visible. The sigmoidal artery is tied in two places and cut between and the proximal stump dropped back into the abdominal cavity. The raw surface in the abdomen is covered by suturing the two peritoneal layers of the meso-sigmoid together over the arterial stump. The two legs of the sigmoid are sewed together laterally to make a spur, after the method of Bodine. The peritoneum is sewed around the bowel; the muscles drawn together; the skin wound closed, attaching it to the bowel. In forty-eight hours the tumor is excised by a V-shaped incision. Two days later, the spur is cut away by pressure-forceps. After this is completed a long rectal bougie is passed up through the bowel beyond the artificial anus, in order to press the spur back and obtain a large caliber at the site of the resection. When the wound made by the pressure-forceps is healed, the artificial anus is closed by the extra-peritoneal method of the author.

THE X-RAYS AS AN AID IN MAKING DIAGNOSIS OF CONDITIONS IN
THE RECTUM AND OTHER PORTIONS OF THE LARGE INTESTINE.

By J. R. Pennington, M.D., of Chicago, Ill.

He stated that while the rectum is easily inspected by various specula, and the sigmoid is less readily accessible by the use of sigmoidoscopes, such as the one with insufflation devised by him, the colon is inaccessible and its exact position difficult to ascertain. Very often it is also difficult to determine and locate pathologic conditions in the large intestines.

Until recently, the means of diagnosis have been limited to those of the alimentary canal, viz.: Inspection after dilatation of the bowel with air or water, palpation, percussion, and transillumination. All of these are open to the objection that they are uncertain.

The writer observed in the latter part of 1899, that by introducing some agent into the large bowel which would cast a shadow, the X-rays may become useful in making a diagnosis of conditions in the two cavities. It is only recently, however, that such procedures have become of practical value.

A bismuth meal is useful in diseases of the stomach or duodenum, the agent being suspended in milk, acacia water, thick soup or some similar vehicle.

But for the large bowel, the action of bismuth per os is very slow. One author estimates that it requires from 12 to 15 hours for the bismuth to reach the ileo-cecal valve; about 24 hours to gain the transverse colon, and 36 hours to penetrate to the sigmoid. But the method advocated this is done, so to speak, instantaneously.

Coming now to the technic: The patient's bowels are first cleansed by means of laxatives and injections. He is then placed in the knee-shoulder position, and from 25 to 30 ounces of the mixture used for casting the shadow injected into the large intestine. For this purpose the author uses an ordinary irrigator

and a short rectal tip. A long rectal or colonic tube for administering the injection is unnecessary. After the suspension is injected the patient lies on his right side for a few moments so part of the menstrum may pass into the cecum. He is then placed in either dorsal or ventral position on the radio-graphic table and the picture taken.

Extracts from Home and Foreign Journals.

SURGICAL

CARCINOMA OF SKIN, EFFECT OF ADRENIN IN.

The author reports a case of skin carcinoma in a man 63 years of age, in which the local use of a 1:1000 solution of the active principle of the suprarenal appeared to exert a marked influence in causing retrogression and final disappearance of the growth. The solution was either painted freely over the tumor surface or a few drops of it injected into the tumor; the injections were followed by edema of the tissues, and were therefore given only on a few occasions. Radium treatment, previously given for some time, had had but little effect. Adrenin was then added, and from the start distinct benefit was noted, the ulcerated area steadily diminishing in size. A wet dressing of lint soaked in the adrenin solution was temporarily stopped, the radium being continued, there was shown a tendency to relapse. The radium was then stopped and the adrenin used alone, at which period the process of healing appeared to be most rapid. Finally, the ulcer was completely covered over, a smooth, hardly visible scar being left. Six years have elapsed since the disappearance of the growth, without any indication of recurrence.

The healing of the ulcer at its margin had apparently been initiated by the adrenin. Its mode of action was obscure. It might have diminished the vitality of the tumor cells by inducing anemia locally, but such an influence would have lasted only a short time. In the process of healing there was no necrosis of the tumor mass, leaving a cavity to be filled up by granulation, but apparently a gradual replacement of the tumor as its periphery by healthy new tissue.—*Monthly Cyclopedic and Medical Bulletin.*

OBSTETRICAL

IODINE IN OBSTETRICS.

Dr. Paul Charrier expounded recently, in a thesis, the excellent results obtained in the service of Dr. Bonnaire (a famous contemporary French obstetrician) from the use of iodine at the first appearance of puerperal infection and even when the infection had already gained a serious stage.

Tarnier is the first author who studied the effects of iodine in puerperal infection, and, in his work on antiseptics in the practice of obstetrics, he recommends a solution of iodine which has become known as Tarnier's solution (*liqueur de Tarnier*), and of which accoucheurs are making constant use. The formula for this solution is: Iodine, 3 Grams (grs. 45); potassium iodide, 6 Grams (grs. 90); boiled water, 1 liter (ozs. 32). This solution contains a relatively small quantity of iodine, and yet it is active in low-grade infections, owing to the very powerful properties of the irodine.

Iodine is in fact intensely diffusible, and volatilizes very rapidly in the uterine cavity, penetrating intimately and profoundly into its tissues. Iodine, in the form of the tincture, seems always to be highly beneficial, and its applications in obstetrics are many. First of all it is a preoperative antiseptic in such operations as symphyseotomy, perineorrhphy, and so on. But most favorably is its action seen when it is used as a preventive.

Here is an example of how Dr. Bonnaire makes use of it. A woman is brought into his service with a miscarriage uncompleted. After trying the usual method to prevent the miscarriage, since the symptoms continue and the temperature does not rise, delivery is allowed to proceed spontaneously. If the delivery is incomplete, then the uterine cavity is cleared out by what in French is called a "*pince-mouchette de Bonnaire*," or else by digital curettage. Then immediately a sterilized compress [properly, a "pledget of sterilized cotton"] is taken up with a uterine dressing-forceps and moistened with tincture of iodine, and while the vaginal cavity is kept wide open and the uterine neck pulled

down and held with a vulsellum, the iodine pledget is introduced into the cavity of the uterus and pushed in until the fundus is felt by the operator, when he touches alternately the two sides of the uterus and its two cornu. Quite as fully the same iodine treatment is indicated as a preventive in the case of artificial (instrumental) delivery.

Another indication for the preventive iodine treatment is when there is a delivery at term, but the child has died in the womb some days before. In a case like this, secondary fermentation ensues and anaerobic bacteria develop, of which the fetid amniotic liquor is proof. Further, there is the delivery before term of a macerated fetus. The delivery in such cases is bad, and the fetuses are nearly always congenitally syphilitic.

Up to now we have referred to the iodine treatment as a preventive. But the same treatment also furnishes the best results in puerperal infection, whether localized or general. In the first case, when a curettement is intended, then a quarter of an hour before the operation the uterine cavity is painted over with a strong solution of iodine, which can be done with a pledget of cotton held by a uterine dressing forceps and dipped in the solution of iodine; this to be repeated two or three times, but always with greatest care.

In order to produce by the curettement the least possible traumatism, Dr. Donnair uses his "pince-mouchette," which detaches the debris adhering to the endometrium, but does not scrape the uterine surface, and he avoids opening the uterine sinuses; thus getting the best chances for success.

Finally, when there is fear of the appearance of a general puerperal infection, the painting over of the uterine cavity with iodine solution may prevent that complication.—*The American Journal of Clinical Medicine.*

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at \$1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D., corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

ANTI-TYPHOID VACCINATION.

Anti-typhoid inoculation is now recognized by the profession as a safe and sane way to prevent, or at least mitigate, an attack of typhoid, and doubtless would be required by municipal authorities were it not for the fact that the public is notably slow to adopt anything suggested by the profession, because there is an inherent belief that any such recommendation is given with selfish motives. Improved sanitation is gradually wiping out typhoid anyway, and so by the time the public is educated to the point of adopting compulsory typhoid inoculation, the disease in cities will be practically nil and so vaccination hardly necessary. However, it has come to stay and will be used in the armies throughout the world, in times of great typhoid epidemics, and by those whose business exposes them to typhoid.

The scientists who have worked out this, deserve great credit, almost as much as Jenner himself. The latter was the pioneer of vaccination, and nothing can detract from the great service he has rendered humanity, but these modern scientists are likewise pioneers in preventive medicine, and it is our humble opinion that our descendants will have them to thank for paving the way to the preventive and prophylactic medicine of the future when diphtheria, measles, scarlet fever, whooping cough, etc., will each and all be held in subjection by a small tube of clear solution—a serum.

We are hardly in accord with those who think all serums, whether prophylactic or therapeutic, the best treatment the pro-

fession can offer, but we do recognize some as wonderful and all as good, inasmuch as they are forerunners of the better ones to come.

VACCINE IN THE TREATMENT OF TYPHOID FEVER.

To the Nashville Journal of Medicine and Surgery:

About six years ago the writer began to use vaccines in the treatment of typhoid fever. Since that time he has thus treated more than one hundred cases and has obtained numerous articles upon the same subject written by physicians in various parts of the world. It seems possible, however, that some may have escaped notice. He also realizes that many of the profession may have treated some cases without reporting them. A paper upon the subject is now in the course of preparation. In this it is earnestly desired to incorporate reports from a large number of cases, good, bad, and otherwise. He accordingly makes the following request to the readers of this journal:

Will anyone who has used vaccines in the treatment of typhoid fever, whether but one case or more, kindly communicate to him that fact, accompanied by name and address of the reporter. If the results have already been reported, a note of the journal in which they appeared will be sufficient. If they have not been reported, a short blank form will be sent to the physician to be filled out. Due credit will be given in the article to each person making a report. If any physician happens to know of other confreres who have any such cases, it will be appreciated if he sends their names, as they may not happen to read this note. It is hoped that by this means a sufficient number of cases may be collected to somewhat definitely settle the now mooted question whether vaccines are not of benefit in typhoid therapy.

Reports of cases will be accepted at any time in the future, but preferably by November or December of the present year.

Kindly communicate with Dr. W. H. Watters, Director of the Department of Pathology and Bacteriology, Evans Institute for Clinical Research, Boston, Mass.

PHYSICIAN (MALE).

Sept. 11, 1912.

The United States Civil Service Commission calls attention to the examination to be held on September 11, 1912, at the various places mentioned in the list printed hereon to secure eligibles from which to make certification to fill vacancies occurring in the position of physician in the different services.

Among the vacancies to be filled as the result of this examination there will be the following in the Indian Service, unless it is found to be in the interest of the service to fill such vacancies by reinstatement, transfer, or promotion:

Colville Agency, Washington, \$1,200 per annum.

Fort Lapwai Sanitarium, Idaho, \$1,000 per annum.

Navajo Agency, New Mexico, \$1,000 per annum.

Navajo Agency, Colorado, \$1,000 per annum.

Pueblo Day Schools, Albuquerque, N. Mex., \$1,000 per annum.

Tongue River Agency, Montana, \$1,000 per annum.

Walker River Agency, Nevada, \$1,000 per annum.

Western Shoshone Agency, Nevada, \$1,000 per annum.

Winnebago Agency, Nebraska, \$1,200 per annum.

Full information in regard to the examination for physician is contained in Section 192 of the Manual of Examinations revised to July, 1912.

Age limit, 21 years or over on the date of the examination, but eligibles who are more than 40 years of age on that date will not be certified except for filling vacancies in the position of acting assistant surgeon in the Public Health and Marine-Hospital Service.

Applicants for positions in the Indian Service are required to be in good health.

Each applicant for a position in the Indian Service must attach to his application a statement concerning the number in his family and the number that will require accommodations at the Indian school or agency in case he receives appointment.

This examination is open to all citizens of the United States who comply with the requirements.

Applicants should at once apply for a copy of the Manual of Examinations and Form 1312 to the United States Civil Service Commission, Washington, D. C., the secretary of the board of examiners, post office, Boston, Mass., Philadelphia, Pa., Atlanta, Ga., Cincinnati, Ohio, Chicago, Ill., St. Paul, Minn., Seattle, Wash., San Francisco, Cal.; customhouse, New York, N. Y., New Orleans, La., Honolulu, Hawaii; old customhouse, St. Louis, Mo., or to the chairman of the Porto Rican Civil Service Commission, San Juan, P. R. No application will be accepted unless properly executed and filed with the Commission at Washington. In applying for this examination the exact title as given at the head of this announcement should be used in the application.

As examination papers are shipped direct from the Commission to the places of examination, it is necessary that applications be received in ample time to arrange for the examination desired at the place indicated by the applicant. The Commission will therefore arrange to examine any applicant whose application is received in time to permit the shipment of the necessary papers.

Issued August 20, 1912.

TRAINED NURSE.—PHILIPPINE SERVICE.

October 16, 1912.

The United States Civil Service Commission announces that the examinations for trained nurse in the Isthmian Canal and the Indian services will be held on October 16, 1912, as scheduled, but that the announcement of the examination for this position in the Philippine service is cancelled because of advice from the Bureau of Insular Affairs that future vacancies in this position in the Philippine service will likely be filled by Filipino women.

Issued August 14, 1912.

OBSTETRICAL CHARTS IN COLORS.

Ten full plates 12x9 illustrating and briefly describing the following obstetrical positions:

1. Diameters of foetal head, pelvic brim and planes of pelvis.
2. Head presentations.

3. Mechanism in left occipito-anterior presentation.
5. Face presentations.
6. Mechanism in face presentations.
7. Right mento-posterior position.
8. Breech presentations.
9. Mechanism in breech presentations.
10. Transverse positions.

These plates will be sent in book form to any address on receipt of 25 cents postpaid.—Battle & Co., Saint Louis, Mo.

NEW YORK POST GRADUATE SCHOOL AND HOSPITAL.

Prof. Dr. H. Strauss, of Berlin, will lecture at the New York Post-Graduate Medical School and Hospital, Second Avenue and Twentieth Street, on October 12, 14, and 15, on the Diseases of the Stomach and Kidney. Prof. Dr. Carl von Noorden, Physician-in-Chief to the City Hospital, Frankfort, Germany, will also deliver a series of lectures on the Pathology and Treatment of Diabetes, Radium Therapy and Arteriosclerosis at the same, on October 28 to October 31, inclusive.—Robert L. Loughlian.

Reviews and Book Notices

Pellagra—History, Distribution, Diagnosis, Prognosis, Treatment, Etiology. By Stewart R. Roberts, I.M., M.D., Associate Professor of the Principles and Practice of Medicine, Atlanta College of Physicians and Surgeons, Atlanta, Ga.; Physician to the Wesley Memorial Hospital; Formerly Professor of Biology in Emory College. With Eighty-nine Special Engravings and Colored Frontispiece. St. Louis, C. V. Mosby Co., 1912.

This excellent work on an old disease made new by its recent appearance in the southern section of the United States is before us. It should prove of unusual interest to Southern physicians, as it has been prepared by a Southern physician, and treats of a disease essentially Southern in its distribution. The awakened interest in this disease for many years prevalent in Southern Europe, and until recently not recognized in this country, is widespread and earnest. Every practitioner should be alive to the fact that he may meet the disease any day, and it should be his duty to reinforce his knowledge of the disease by referring to such a book as this. This little volume is a carefully prepared treatise on the subject of Pellagra, treating of the disease from the standpoints of its etiology, distribution, diagnosis, prognosis and treatment. The author is to be congratulated upon having prepared a work that will prove of great value in the hands of his confreres, and the profession should extend a hearty welcome to this worthy claimant to its favor.

Arteriosclerosis—Etiology, Pathology, Diagnosis, Prognosis, Prophylaxis and Treatment, With a Special Chapter on Blood Pressure. By Louis M. Warfield, A.B., M.D., Assistant Superintendent and Resident Physician to Milwaukee County Hospital, Assistant Professor of Medicine, Wisconsin College of Physicians and Surgeons, Milwaukee, Wis.; Formerly Medical House Officer, John Hopkins Hospital, Baltimore, Md.; Member American Medical Association. With an Introduction by W. S. Thayer, M.D., Professor of Clinical Medicine, John Hopkins University. Illustrated with Twenty-eight Engravings. St. Louis, C. V. Mosby Co. 1912.

We acknowledge with thanks to the publishers the receipt of the second edition of this excellent brochure and take great pleas-

ure in giving evidence to the great practical value of the work to the medical profession. The important role played by arterial degeneration in the etiology of disease, and the production of the fatal termination in a great majority of instances, is well known. A work that is intended to make clear the beginnings, the cause, and conclusions of this condition so universal in every class in this strenuous age is obviously valuable to every physician. In its second edition the work has been entirely rewritten and much valuable matter added. Several entirely new chapters have been added, especially noteworthy being that on "Arteriosclerosis in Its Relations to Life Insurance." We regard the work as a valuable working manual for the practitioner and recommend it to every one who desires a fuller information on an important subject.

A Text-Book of Pathology for Students of Medicine. By J. George Adami, M.A., M.D., F. R. S. Strathcona Professor of Pathology, McGill University, and Advisory Pathologist to the Montreal General and the Royal Victoria Hospitals, Montreal Canada. Late Fellow of Jesus Hospital, Cambridge, England., and John McCrae, M.D., M. R. C. P. (London), Lecturer in Pathology and Clinical Medicine, McGill University, Montreal; Senior Assistant Physician, Royal Victoria Hospital; Sometime Professor of Pathology, University of Vermont; Late Fellow in Biology, University of Toronto, Toronto, Can. Illustrated with 304 Engravings and 11 Colored Plates. Lea & Febiger, Philadelphia and New York. 1912.

The authors in their preface offer explanations of the appearance in a comparatively short time of two large publications on the same subject—the first consisting of two elaborate volumes on the Principles of Pathology, the other, the one now before us of one volume of seven hundred pages, entitled a Text-Book of Pathology. They contend that the latter is not merely a condensation of the former, but that while the larger work contained the material conclusions of the authors upon the subject, the present work is a selection, and dwelling upon what they consider most important for the student. In fact this volume has been prepared especially to meet the needs of the student, and from what we have been able to see it is an ideal text-book for the student. The work is divided into two parts. Part I treats of General Pathol-

ogy; Part II of Special and Systemic Pathology. The work is well adapted to serve the purpose of a working text-book, and we feel sure it will be warmly welcomed by the student body as a clear, concise and yet comprehensive treatise upon a most important department of medicine.

The Practice of Medicine. A Manual for Students and Practitioners.

By Hughes Dayton, M.D., Formerly of the Cornell University Medical School, New York. New (2d) Edition, Thoroughly Revised. 12mo, 326 pages. Cloth, \$1.00, net. The Medical Epitome Series. Lea & Febiger, Publishers, Philadelphia and New York. 1912.

The second edition of this admirable handbook, enlarged and revised, is before us, and we take pleasure in bestowing upon this edition even greater praise than was given the work in the first edition. The author has succeeded in preparing a work that carries out completely the object of the Medical Epitome Series, which is to present a concise, carefully arranged, and as thoroughly as possible within the limits afforded an exposition of the various medical subjects treated of by the different authors as go to make them of value to medical students and practitioners. We take great pleasure in recommending this particular book as among the best of the series.

Progressive Medicine. A Quarterly Digest of Advances, Discoveries, and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D. Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; one Time Clinical Professor of Diseases of Children in the University of Pennsylvania; Member of the Association of American Physicians, Etc. Assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia; Ophthalmologist to the Frederick Douglas Memorial Hospital; Instructor in Ophthalmology, Philadelphia Polyclinic Hospital and College for Graduates in Medicine. Vol. III, September, 1912.—Diseases of the Thorax and Its Viscera, Including the Heart, Lungs, and Blood Vessels—Dermatology and Syphilis—Obstetrics—Diseases of the Nervous System. Lea & Febiger, Philadelphia and New York. 1912.

The September number of this excellent quarterly publication has been received. This periodical fills a place that no other pub-

lication does, in that the improvements, recent advances and comments on scientific progress are presented under the management of its excellent editors and a corps of distinguished contributors. It represents the cream of current medical literature. The contents of this number are: "Diseases of the Thorax and Its Viscera, Including the Heart, Lungs and Blood Vessels," by Wm. Ewart, M.D., F.R.C.P.; Dermatology and Syphilis," by Wm. S. Golthert, M.D.; "Obstetrics," by Edward P. Davis; "Diseases of the Nervous System," by Wm. G. Spiller, M.D. Every up-to-date practitioner should be a subscriber to this invaluable publication.

Publisher's Department

ELIXIR SALOFORM COMP., FLEXNER.

Contains 20% alcohol. An efficient remedy for rheumatism, gout, cystitis and uric acid solvent. Prepared for physicians' prescriptions only.—Robinson-Pettet Co., incorporated.

"That proper elimination is of the utmost importance to the well-being of mankind is amply proven by nature's elaborate system of eliminative and detoxifying organs."

Tongaline, by its highly stimulating action on the liver, the bowels, the kidneys and the pores is the ideal eliminative," and will promptly and thoroughly expel all poisons which have accumulated in the system as the result of sluggish excretory organs.

THE CONTROL OF PAIN.

The work of the conscientious physician is many sided and diverse, but no part or detail of his manifold duties is ever more obligatory or imperative than the control of pain. In the presence of physical suffering any other consideration than its prompt and positive relief, with rare exception, becomes of secondary impor-

tance. But insistent and pronounced as the physician's duty always is to control and assuage the pains to which human flesh is subject, it should ever be his aim to accomplish this noble purpose in the best, as well as in the quickest possible way. Otherwise, with regard only for a patient's comfort, it is extremely liable that the agencies of relief will be attended by consequences serious in the extreme and not infrequently more harmful in effect than the original pain itself.

The foregoing has particular significance for the cautious physician, inasmuch as he has in Papine a pain-relieving measure that enables him to control pain promptly and effectively, with the least possible untoward action. Representing as it does all the anodyne properties of the most potent opiate, but with the usual objectionable features reduced to a minimum, Papine is undoubtedly the most efficient analgesic at the command of the profession. Compared with the useful opiate, Papine will be found much more free from those disagreeable effects ordinarily considered inseparable from preparations of opium, such as constipation, nausea, gastro-intestinal derangement, and tendencies toward habit formation. Thus it can be employed in a wide variety of conditions with confidence, not alone in its anodyne and sedative action, but equally in its avoidance of disagreeable or unpleasant by-effects. In brief, Papine is the ideal preparation of opium, presenting all the advantages of this well-nigh indispensable drug with its nauseating, constipating and habit-forming tendencies reduced to a minimum. Innumerable physicians use it to the exclusion of all other opiates since it enables them to secure all of the well known benefits of the most potent opium derivative—with gratifying freedom from the usual disadvantages.

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NASHVILLE JOURNAL — OF — MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

VOL. CVI.

OCTOBER, 1912.

No. 10.

Original Communications

HERNIAS OF THE UTERINE ADNEXÆ.

BY AIME PAUL HEINECK, M.D.,
Surgeon to the Cook County Hospital. Chicago.

(Concluded from last month.)

GLUTEAL, SCIATIC OR ISCHIADIC HERNIAS.

This is a very uncommon condition. In the medical literature of the last one hundred and fifty years, only twenty-three cases are recorded (E. Koepl). This class of hernias escape from the abdominal cavity by way of either the greater or the lesser sacro-sciatic foramen. There are three varieties: The supra-pyiformis, the infra-pyiformis and the spino-tuberosa. These hernias may be congenital or acquired, may occur on either side of the body and are subject to all the complications of hernia in general. Thirteen of the cases on record were observed in women. Schilbach's case is the only one on record making its exit through the lesser sacro-sciatic foramen. The diagnosis was first made at the autopsy table. During life, there had been genital hemorrhage and symptoms of ileus. At the post-mortem examination the ovary was found in the hernial sac, the tube and the broad ligament being caught in the hernial ring.

We found only two cases of ischiadic hernia of the uterine appendages. Both were acquired hernias of the right tube and

ovary, occurring in multiparous patients. Both were subjected to operation and recovered.

Woelfler's case is interesting in that it was successfully subjected to an operation for radical cure. The hernia, an infra-pyiformis one, emerged like all others of its type along the lower border of the pyiformis muscle in close relation to the internal pudic, inferior gluteal and sciatic nerves and vessels. For the previous two years, the patient had had attacks of pain radiating along the course of the sciatic nerve, and abdominal suffering associated with nausea and, at times, vomiting. In the right gluteal region, there could be palpated below the muscles, a globular, fluctuating, fist-sized, non-reducible swelling from which, at one time, there was removed by aspiration fifty cubic centimeters, and, at another time, five hundred cubic centimeters of dark reddish fluid containing much albumin, red blood corpuscles and leucin-tyrosin crystals.

The following operation was performed: An eight centimeter long incision, parallel to the course of the fibres of the gluteus maximus, was made over the summit of the hernial swelling. The muscle fibres were separated; the hernial sac exposed, isolated and opened. It contained the ovary and the end of the tube. The sac contents were ablated; the resulting stump reduced in the abdominal cavity. The sac was then ligated and cut off; after which, the operator closed the hernial orifice by approximating the pyiformis muscle to the lesser sacro-sciatic ligament.

OBTURATOR HERNIAS.

In obturator hernias, the herniated viscus or viscera, always escape from the abdominal cavity by way of the obturator or sub-pubic canal. These hernias, though less infrequent than sciatic hernias, are nevertheless uncommon; not more than two hundred cases are recorded in the medical literature.

They are usually small; may be unilateral or bilateral (are more frequent on the right side); may co-exist with hernias of a different type. They may be reducible, irreducible or strangulated.

Picque and Poirier recognize three main anatomical varieties

of obturator hernia. In the first variety, the most common, the hernia follows the entire course of the obturator, appearing as a swelling in front of the external orifice of this canal. In the second variety the hernia escapes from the abdominal cavity through the pelvic orifice of the sub-pubic canal, but following the course of the inferior division of the obturator nerve; does not traverse the canal's entire length, and makes its exit by passing between the superior and middle bundles of the obturator externus muscle. In the third variety, the hernial protrusion also enters the pelvic orifice of the obturator canal, but becomes lodged between the obturator membrane and the obturator externus muscle.

Objective symptoms are frequently absent. When a swelling is visible and palpable, it is usually of small volume, and is located in the most internal portion of Scarpa's triangle, somewhat resembling a femoral protrusion. It is, however, non-pediculated and does not extend in the direction of the crural canal. In suspected cases, one should always determine whether there is increased pain when the obturator externus is put under tension abduction and rotation inward of the thigh.

Vaginal examination is important. The internal orifice of the sub-pubic canal is accessible to the vaginal hand.

Two routes are advised for the treatment of obturator hernias: The abdominal route and the obturator route. In the obturator route, the following steps are employed:

1. An incision eight centimeters long is made about three and a half centimeters internal and parallel to the femoral artery.
2. Separate with a grooved sound the internal border of the pectineus muscle from the outer border of the adductor brevis and adductor longus muscles.
3. If necessary, divide a few of the fibres of the pectineus muscle close to their insertion on the pubic bone, so as to facilitate digital exploration of the obturator region.
4. Expose, isolate and open sac; determine its relation to the obturator nerve and vessels, after which nick constricting point if hernia be strangulated and reduce or ablate hernial contents.
5. Closure of wound.

FEMORAL HERNIAS.

Hernias, which in their escape from the abdominal cavity pass between Poupart's ligament and the horizontal ramus of the pubis and sooner or later protrude in Scarpa's triangle, are called femoral hernias. Common femoral hernias escape from the abdomen through an orifice bounded anteriorly by the most internal portion of Poupart's ligament; posteriorly, by the horizontal ramus of the pubis; externally, by the femoral vein and the sheath of the femoral vessels; internally, by Gimbernat's ligament. They descend along the most internal compartment of the femoral sheath and ultimately emerge through the saphenous opening. These hernias are contiguous to the femoral vein which always lies external, and they carry along in their progress through the crural canal a mass of condensed areolar tissue, known as the septum crurale. They show a greater tendency to expand upward than downward, because the cribriform fascia is less adherent to the upper margin of the saphenous opening.

The small number (sixteen cases) of femoral hernias which we were able to collect, as compared to inguinal hernias, confirms the now accepted but previously disputed fact that, in the female, inguinal hernias are of more frequent occurrence than femoral hernias. All these femoral hernias were of the acquired type; it is known that congenital femoral hernias are pathological rarities. A femoral hernia is essentially a hernia of adult life. Either side of the body may be involved. The tendency to double femoral hernia is less than that to double inguinal hernia. All femoral hernias, irrespective of contents or of sex of bearer, are of more frequent occurrence on the right side (Wernher, Macready, Berger).

The tubal hernias contained the oviduct either in part or in its entirety, alone or associated with intestine, omentum or both. The presence of the appendix vermiformis in a femoral hernial sac is rare. Coley states that in 2,200 cases of hernia operated upon from 1890 to March 1908 in the Hospital for Ruptured and Crippled, the appendix vermiformis alone was found in ten, the cecum and appendix together in seven. In not a single one of

Coley's cases was the appendix found in a femoral hernial sac. (W. B. Coley, Keen's Surgery, 1908, vol. I, p. 78.)

These hernias may be reducible, irreducible or strangulated. Strangulation can occur at any one of the following sites:

- (a) Internal femoral ring.
- (b) Margin of Gimbernat's ligament.
- (c) Margin of the saphenous opening.
- (d) Meshes of the cribriform fascia.
- (e) Irregularities in the hernial sac.

The following operations were performed:

- (a) Amputation of fimbriated end of tube.
- (b) Incision of hernial swelling and creation of an artificial anus.
- (c) Ablation of tube.
- (d) Ablation of ovary.
- (e) Ablation of tube and ovary.
- (f) Excision of hernial sac and return of tube to abdominal cavity.
- (g) Removed tube and ovary and resected gangrenous intestine.

Truss treatment of femoral hernia is notoriously unsatisfactory and is considered as being only palliative and not at all curative. In femoral hernias, on account of motions of thigh, it is difficult to apply, and especially to maintain pad-pressure in a position conducive to closure of the hernial openings.

Coley whose clinical experience with the treatment and cure of hernia is greater than that of any living American surgeon, supplements to high ligation and ablation of the hernial sac with the thorough removal of all extra-peritoneal fat the following step: He introduced a purse-string suture of kangaroo tendon in such a way as to bring the floor of the femoral canal in contact with the roof.

INGUINAL HERNIAS.

Hernias which escape from the abdominal cavity, either through the internal or external inguinal fossae, and which emerge upon the surface when complete by way of the external

abdominal ring, are known as inguinal hernias. Of all hernias, they are the ones most frequently noted in the female.

Inguinal hernias of the uterine adnexæ may be complete or incomplete. In the incomplete form, the hernia has not escaped beyond the external abdominal ring. Inguinal hernias may be right-sided or left-sided. They may be unilateral or bilateral. As previously stated, all the bilateral hernias of the uterine adnexæ, tubal, ovarian or tubo-ovarian, recorded in the medical literature of the last twenty years, were of the inguinal variety. They may be reducible or irreducible. They may be strangulated or the seat of torsion. This last accident has only been observed in congenital inguinal hernias, the contents of which were irreducible.

Of the uncommon types of inguinal hernias only several could be found. There was one direct hernia. This, especially in the female, is an uncommon form. The main characteristics of direct hernias are that the protrusion takes place by way of the internal inguinal fossa, that the neck of the sac is always to the inner side of the deep epigastric vessels and, in the female, that the round ligament is distinct from and to the outer side of the sac. We found three interstitial or intra-parietal hernias. All the other inguinal hernias were of the ordinary type, that is, external or indirect or oblique. An ordinary or oblique inguinal hernia in its course through the inguinal canal (narrower in the female than in the male) is accompanied by the round ligament; as it escapes from the external abdominal ring, it appears in the upper portion of the labium majus, in which it descends to a greater or less extent.

Inguinal hernias vary in size and in form. They may be almond-shaped, ovoid, sausage-shaped, pear-shaped, pyriform, globular or other form too numerous to mention.

SYMPTOMS AND DIAGNOSIS.

Hernias of the uterine appendages present all the symptoms common to hernias in general. In some hernias of slow and gradual development, owing to the absence of symptoms, not uncommonly the patient ignores that he has a rupture. Some cases

do not give rise to any symptoms; some give rise to very slight disturbances; many remain painless until the appearance of the menses and thus are first recognized at about the age of puberty. Pain may be absent during the entire course of a slowly developing hernia. In other cases, the hernial swelling may be so small as to be completely overlooked by a careless observer. Inspection, palpation and percussion of the hernial regions are routine steps in the examination. After having demonstrated the presence of a hernia, the operator has to determine the type of hernia present and the nature of its contents. The existence of other malformations is to be ascertained as they may be of such a nature as to partially justify the sacrifice of healthy herniated organs.

Clinicians usually do not experience any difficulty in diagnosing a hernia; at times, they are in doubt as to the type of the hernia present in the case at hand. In fatty individuals, the exact position of the hernial nick is difficult to determine. Obturator hernias are rare, and are found internal to the femoral opening; in femoral hernias, the swelling is found to be almost if not entirely below a line extending from the anterior superior iliac to the pubic spine.

In the female, the tumor-mass caused by a complete oblique inguinal hernia, even of a moderate size, will cause a swelling extending into the labium majus.

In some hernias of the uterine appendages, the patients complain of a feeling of weight and discomfort. The symptom, "tenderness on pressure", we find frequently reported. Some of these hernias are painless, some are so painful as to interfere very much with the patients' well-being. Impulse on coughing is not infrequently noted. It is not, however, a constant symptom present; it may be absent. Menstrual disturbances are recorded.

If an oblique inguinal hernia be incomplete, that is, if it does not extend beyond the inguinal canal, it may be mistakenly diagnosed tumor of the round ligament, bubo, epiplocele or encysted hydrocele of the canal of Nuck. In tumors of the round ligament, epiploceles, encysted hydroceles of the canal of Nuck, a mistake in diagnosis is not very significant, as in all these condi-

tions one must, to obtain cure, resort to operative treatment and to exposure of the inguinal canal.

TREATMENT.

Six of the reported cases were either autopsy-table or dissecting room discoveries. In some cases, the nature of the operative intervention is not stated. In the other cases, the operators, after performing either a laparotomy or a herniotomy, disposed of the herniated organs either by reducing or removing them entirely or by removing a part and reducing the remainder. In some cases, the reduction of the hernial contents necessitated a preliminary division or a dilatation of the hernial rings, internal or external.

In two hundred and thirteen operated cases the results are stated: 11 deaths; 202 recoveries.

We advise that all hernias of the uterine appendages, irrespective of anatomical site or of size or of age of bearer, be subjected to an operation for radical cure:

- (a) If the hernia be irreducible.
- (b) If the hernia be strangulated.
- (c) If the pedicle of the herniated organ or organs be the seat of torsion.

After the age of two years —

- (a) If the hernia be bilateral.
- (b) If other hernias be co-existent.
- (c) When hernia can not be painlessly, completely and permanently kept reduced.
- (d) If organs other than the uterine appendages be also present in the same hernial sac.
- (e) If the wearing of a hernial truss causes pain or aggravates the symptoms.

(f) If the patient has to be subjected to ether or chloroform anæsthesia for the performance of an operation of election, double advantage can be taken of this anæsthesia, and an operation for the radical cure of the hernia performed.

- (g) If the patient is exposed to pregnancy.

Operation in uncomplicated hernias of the uterine adnexæ is no

more dangerous than the operation for the radical cure of other hernias. It has practically no mortality. Infants bear hernia operations remarkably well. Broca performed four hundred and fifty operations in children under fifteen years of age with but one death.

The operation which has given the most universal satisfaction in the treatment of inguinal hernias is that devised by Bassini. It has the advantages of safety, simplicity and efficacy.

We advise operators to observe in their operations for inguinal hernia the following suggestions:

1. Always wear, and have the assistants wear, rubber gloves.
2. All ligatures and irremovable buried sutures should be of absorbable material. The purpose of sutures is to keep divided tissues in apposition until organic union has been effected. After this has been accomplished, sutures if not absorbed or not removed may originate irritation, may act as predisposants to inflammation, to sinus formation. We strongly condemn the use of silk for vessel ligation or for buried sutures.
3. Always divide the aponeurosis of the external oblique muscle to an extent sufficient to give a good exposure of the inguinal canal, and of its contents. In the female, the inguinal canal in its normal state and after a hernia operation, in its restored state, should, outside of a few arterioles and nerve filaments, contain nothing but the round ligament, a structure much smaller than the spermatic cord, and if the latter is not the seat of disease should never be sacrificed.
4. Always make a high and careful dissection of the hernial sac from the surrounding tissues, and especially from the round ligament to which it is often quite intimately adherent.
5. Always open the sac and determine by direct inspection and palpation the nature and state of the hernial contents.
6. After reduction or ablation of the hernial contents the sac is to be transfixated and ligated as high as possible. Sac is then removed flush with the peritoneal cavity. So as to prevent the occurrence of peritoneal bulging at the internal ring, we are in the habit of anchoring or fixing the stump of the sac about two centimeters above this point.

7. Never sacrifice the round ligament; it is harmful to the statics of the uterus. Never transplant the round ligament; it is unnecessary. The round ligament is left undisturbed at the bottom of the wound, emerging at the lower angle of the latter; the internal oblique muscle is sutured to the shelving portion of Poupart's ligament; the divided margins of the external oblique aponeurosis are sutured and the skin incision closed. No drainage. After operation, no truss should be worn; a truss does not support the scar, it weakens it.

8. In the female, the internal and external abdominal rings can be closed without detriment to the patient. In direct inguinal hernias, ligation of the deep epigastric artery is at times unavoidable.

In hernias of the uterine appendages, the operator must decide as to whether the hernial contents are to be returned to the abdominal cavity or whether they are to be removed.

As to the herniated tube, ovary or tube and ovary, when normal, it goes without saying that they should be returned, irrespective of patient's age; if adherent to sac-wall or to some hernial content the adhesions are to be loosened or divided, and if the organ or organs do not show marked structural impairment, they are to be reduced. These organs, when herniated, should be removed, if they be the seat of:

- (a) Unavoidable or actual gangrene.
- (b) Benign neoplastic disease.
- (c) Malignant neoplastic disease.
- (d) Voluminous cyst formation.
- (e) Malformation or incomplete development.
- (f) Suppurative inflammation.
- (g) Hematoma or intestinal ovarian hemorrhage.
- (h) Seat of tubal gestation previous or subsequent to rupture of fetal sac.
- (i) Tuberculosis limited to or extending beyond the herniated organs.
- (j) Distortion beyond recognition.
- (k) Such pathological changes as prevent function.

SUMMARY.

1. The fallopian tube, the ovary or the tube and ovary, in part or in their entirety, may be herniated.

2. The herniated tube, ovary or tube and ovary may be the sole content of the hernial sac or there may be present as associated hernial contents one or two or more of the following structures or organs: Meckel's diverticulum, appendix vermiformis, omentum, urinary bladder, intestine (small or large), uterus.

3. Tubal, ovarian and tube-ovarian hernias are congenital or acquired, unilateral or bilateral; exist alone or in association with one or more other hernias of the same or of dissimilar anatomical types, of the same or of dissimilar clinical characteristics.

4. These hernias, in a small proportion of cases, coexist with malformations, underdevelopment or absence of other internal genitalia or of some external genitalia. Imperforate vagina, absence of vagina, atresia of tube, unilateral absence of tube, of ovary or of tube and ovary, absence of cervix uteri, rudimentary uterus, absence of uterus, etc.

5. In individuals having a hernia of a tube, an ovary or of a tube and ovary, pathological states of other internal genitalia or of some external genitalia may be present. Vaginitis, ovarian cystoma, uterine fibroid, uterine prolapse and other uterine displacements, etc.

6. These hernias may coexist with pathological states of organs other than the internal or external genitals; chronic hydrocephalus, multiple stenosis of intestines, hydronephrosis, etc. These coexisting pathological states having no relation of cause or effect to the hernial infirmity.

7. Congenital or acquired hernias of the tube, ovary or tube and ovary, may develop at any period of life. These hernias have been observed in nulliparæ, in primiparæ and in multiparæ. No age is exempt. No race is immune.

8. According to their anatomical site, hernias of the uterine appendages are designated as post-operative or ventral, gluteal, sciatic or ischiadic, obturator, femoral and inguinal.

9. The tube, the ovary or the tube and ovary may be present

alone or in association with other organs in the sac of any variety of gluteal, obturator, femoral or inguinal hernias.

10. Clinically, these hernias are reducible, irreducible, non-inflamed, inflamed, strangulated or their pedicle may be the seat of torsion.

11. Torsion of the pedicle of a herniated ovary or of a tube and ovary, an accident peculiar to, and not infrequent in, hernias of the uterine appendages, gives the same clinical symptoms and determines the same anatomical changes in the herniated organs as are observed in the strangulation of hernial contents at one or another or more points.

12. We were able to collect eight times as many hernias of the inguinal type as of all the other hernial types put together.

13. Tubal, ovarian and tubo-ovarian inguinal are recent, old or recurrent; are direct, interstitial or intra-parietal, indirect or oblique. If indirect or oblique, they are either complete or incomplete. A few sliding hernias are on record.

14. All the bilateral, tubal, ovarian or tubo-ovarian hernias recorded in the medical literature of the last twenty years were of the inguinal variety. In bilateral hernias, both hernias may or may not show the same degree of development; they may have appeared simultaneously or one may have appeared a shorter or longer time before the other. They may show similar or dissimilar clinical characteristics. When bilateral, one hernia may be irreducible and the other reducible.

15. All the hernias in which the complication "torsion of the pedicle" occurred were irreducible congenital inguinal hernias.

16. All the femoral tubal, ovarian or tubo-ovarian hernias recorded in the medical literature of the last twenty years were of the acquired type and appeared in advanced adult life. "Femoral hernia is essentially a hernia of adult life."

17. Hernias of the uterine appendages, in the absence of anomalies of the other internal genitalia or of the external genitalia, do not prevent conception, do not interfere with gestation, nor unfavorably influence parturition. Pregnancy can occur previous to, during and subsequent to the existence of hernias of this nature.

18. The etiology of hernias of the uterine appendages is that of hernia in general. As main factors should be cited: All conditions that weaken the abdominal wall, all conditions that increase the intra-abdominal pressure and all conditions that increase the mobility of the uterine adnexæ. Heredity, pregnancy and the partial or complete persistence of the canal of Nuck are the most important causes.

19. The herniated organ or organs may be free from all degenerative changes.

20. The herniated organ or organs may be bound to the sac-wall or to each other; may be the seat of congestion, gangrene, hemorrhage, inflammation, suppuration, tuberculosis (primary or secondary, cystic and neoplastic disease (benign or malignant)).

21. The herniated organ may be the seat of gestation.

22. The hernial sac and the herniated adnexa or adnexæ may be the seat of an inflammation, suppuration or other in character, which in progressing by continuity of surface has extended upward from the vagina, giving us the following anatomical picture: Vaginitis, endocervicitis, endometritis, salpingitis or pyosalpinx, ovaritis and saccular peritonitis.

23. The hernial sac and the herniated contents may be the seat of an inflammation, suppurative or other in character, which has reached the tube and ovary by way of the parametrial and parasalpingeal connective tissue.

24. Pathological processes originating in the hernial contents may, by extension, by contiguity of tissue, involve the sac and its overlying tissues.

25. The hernial sac and the herniated tube, ovary or tube and ovary, can become the seat of pathological processes secondary to disease of the associated hernial contents. Epiploitis, appendicitis, gangrenous gut, etc. Infection spreading by contiguity of surfaces.

26. The herniated tube, ovary or tube and ovary and the associated hernial contents may be free of disease, or the uterine adnexæ may be normal and pathological changes be present in the associated hernial contents: Appendicitis, gangrenous gut,

epiploitis, etc. The associated hernial contents may be normal and the herniated uterine adnexæ be the seat of morbid changes.

27. It is at times difficult, at times impossible, to state with absolute precision whether the anatomical changes present in the herniated organ or organs developed previous to or subsequent to the displacement of the tube, ovary or tube and ovary into the hernial sac.

28. Truss treatment for hernias of the uterine appendages is curative, is often productive of discomfort and interferes with the nutrition and development of the herniated tube or ovary.

29. Women who suffer from any form of hernia should be carefully watched before, during and after their confinement so as to prevent or rather minimize any undue strain upon weak regions of the abdominal wall. These women, at the close of lactation or towards the end of the first year following their confinement, should in the absence of contraindications be subjected to an operation for radical cure of the hernia.

30. In the female, all hernias, irrespective of anatomical site, of clinical condition or of nature of contents, should, in the absence of a constitutional state contraindicating operations of election, be subjected to an operation for radical cure.

31. Clinical conditions so closely simulating hernias of the uterine appendages that a positive diagnosis without operation appears impossible, should be subjected to operative treatment. Only benefit can be derived from adherence to this rule. A diagnosis is established and a cure is effected.

32. In these hernias as in all other hernias, the ideal time for operation is previous to the development of degenerative or other pathological conditions in the herniated organ or organs and previous to the occurrence of any of the various complications incident to hernias.

33. The mortality of operations for the radical cure of hernias, if performed at an opportune time and by a rapid operator competently assisted, is nil.

34. To be effective, operations for radical cure of hernias must well fulfill two essentials: The suppression of the sac and the strengthening of the area through which the hernia has escaped.

35. In all herniotomies, the sac should be incised and the hernial contents examined.

36. In the female, the inguinal rings are comparatively small. They can, without inconvenience to the patient, be closed.

37. The herniated normal tube or ovary should never be sacrificed. These organs have an important role, and in the absence of marked structural impairment should be returned to the abdominal cavity.

38. The herniated abnormal tube, abnormal ovary or abnormal tube and ovary should be removed if their return to the abdominal cavity is associated with peril, immediate or remote, to the patient, or if these organs are so altered anatomically as to be functionally worthless. In sacrificing tissues or organs, the surgeon must be economical.

39. Until we are better informed as to the frequency and nature of true and false hermaphroditism, removed herniated uterine adnexæ not having a distinctive structure, should be subjected to a microscopical examination. This will avoid mistaking testicular for ovarian tissue and vice versa.

40. In the treatment of strangulated sciatic or gluteal, obturator and femoral hernias of the uterine appendages in which the hernial sac also contains gangrenous gut, a double operation is almost always indicated: A laparotomy for the repair of the intestinal lesions and a herniotomy for the radical cure of the hernia.

Selected Articles

A CLINICAL TALK ON ECTOPIC GESTATION.*

By H. S. Lott, M.D., Winston, N.C.

The *first* thing for us to remember about ectopic gestation is, that it is a *reality* and not a *myth*, and that its victims are dying about us every day from *rupture* and *hemorrhage*—*unrecognized*.

The symptoms of rupture are those of sudden loss of blood from any cause. They comprise chiefly sudden, violent, and "sickening pain," with a quickened pulse, pallor, and collapse, if the hemorrhage is great and invades vital parts.

Parry, of Philadelphia, whose classic portrayal of extra-uterine pregnancy excels all others in point of clearness, of clinical detail, and also as to the pathology concerned, says that rupture may occur as early as the third week, and in his tabulated cases took place most often in the eighth week and as late as the twentieth and even the twenty-eighth.

Among the causes of this accident, Parry lays especial stress upon the "emotions." He cites a number of cases in which fear, anger, and sudden shock were so closely related that they must have had a causative influence. He says, "At first no importance was attached to the matter, but closer study led to the conclusion that we can not deny the influence of strong emotions, occurring during or shortly after intercourse, as a cause of extra-uterine pregnancy." This fact is further borne out in the statistical evidence that more ectopic gestations occur in women who are guilty of illicit intercourse than in those in the marital relation. No doubt physical distortions and functional derangements play their part, and an important one; but the bulk of evidence is in favor of the emotional factors being paramount.

Ectopic gestation is the more comprehensive term, embracing, as it does, all varieties of erratic conception; whereas extra-

*Presented by request to Forsyth Co. Medical Society, May 14, 1912.

uterine pregnancy only applies to those cases in which the implantation is beyond the limits of the uterine wall. Various good classifications have been made, but that of Parry seems to me the most simple and practical one.

Parry's classification embraces the following classes: 1. Tubal pregnancy. 2. Ovarian pregnancy. 3. Ventral or abdominal pregnancy.

1. Tubal pregnancy has the following varieties:

(a) Tubo-ovarian, the ovum being arrested in the pavilion, which contracts adhesions with the ovary.

(b) Tubo-abdominal, the ovum being arrested in the same locality. The tube may contract adhesions with neighboring organs. If it does not, the chorion may project into the abdominal cavity, with a part of its surface bare.

(c) Tubal proper, the ovum being arrested between the pavilion and that portion of the oviduct which traverses the uterine wall.

(d) Tubo-uterine, the ovum being arrested in that portion of the tube which passes through the uterus.

2. Ovarian pregnancy presents the following varieties:

(a) Ovarian proper. The ovum is contained in the ovary, that organ remaining free from adhesions.

(b) Ovario-tubal. The ovum is contained in the ovary, which contracts adhesions with the pavilion of the tube.

3 Ventral or abdominal pregnancy occurs as:

(a) Primary. The ovum is developed from the outset in the peritoneal cavity.

(b) Secondary. The development commences in the tube or ovary, the cyst ruptures, the ovum escapes and continues to live and develop in the peritoneal cavity.

Now, this division of the classes into varieties is valuable, and if such distinctions could be made in differentiation at the outset, before the inevitable *accident* and before the abdomen is opened, this would have practical bearings upon the prognosis and treatment; but we know that such is not the case, as the following clinical discussion will testify.

Certain conditions are distinctly surgical; ectopic gestation is .

one of these. Just why it occurs, the various theories advanced have not explained to our entire satisfaction. That it does occur, and frequently, is the main fact of vital interest. Most cases are supposed to have a previous history of sterility, but that this is not invariably the rule I will show directly. The accident is most frequent in women who have never borne children; but to this also there are exceptions, showing that the impregnated ovum may pursue this erratic course and implant itself upon soil beyond the uterine cavity at all times throughout the child-bearing period.

The various points at which such an impregnated ovum may stop and begin its growth may be traced from the ostium internum of each Fallopian tube throughout the extent of their lumen: or migrating further and leaving the tube by way of the ostium abdominale, it may drop into the peritoneal cavity. There it may graft itself near the ovary, or, most likely, within the folds of the broad ligament, and from this site, as its growth advances and if the woman survives the rupture, which is sure to come, it may, at last, find its way into the retro-uterine pouch of Douglas.

Implantation, with growth of the ovum at any of these points beyond the uterine cavity, is sure to bring disaster. Those cases where gestation occurs in the proximal half of the tube seldom reach the surgeon, as they are most apt to prove fatal at the time of rupture and die without the condition being recognized or are reported by the coroner.

Ruptured ectopic gestation is a clear case of bleeding from a torn artery; and, in the light of today, should be recognized and the patient saved. Would you hesitate in the presence of a stab wound of the femoral artery, or would you cut down and tie the bleeding vessel?

The diagnosis, with the clinical picture once established in our minds, should not be difficult. In most cases there is a history of several years of sterility; then a suspicion of pregnancy; and during the early months, either with or without slight menstrual "show", the sudden occurrence of "intense abdominal pain, followed by anxious countenance, acute anemia, and collapse" (Price). Any case in doubt will become clear upon making the

incision through the abdominal wall, as the omentum will be found black—flooded with blood.

Of those cases occurring in the distal half of the tube, with growth and development there and elsewhere within the range of possibilities, two notable ones have come under my observation.

The first one was a colored woman, seen in consultation. She was about twenty-six years of age and had been married several years without any pregnancies. Her attending physician reported that she had been suffering for several days with very severe abdominal pains, and that hypodermics of morphia failed to give her entire relief. The patient's condition, when I visited her, bore out his description. I found her lying on the bed moaning with the pain and unable to keep in one position. Seating myself at the bedside, I watched her for a while. The woman seemed to be well nourished and in very good physical condition. Her eyes were clear and bright, the tongue clean, and the lips of a healthy color. The breasts gave no distinctive evidence, and there was no distention of the abdomen. The pains were distinctly recurrent and paroxysmal, the woman's attitude during the height of their intensity suggesting an expulsive character. As the wave of pain arose, the pulse would quicken, and she would change her position constantly in the bed and make very bitter complaint of her sufferings.

Upon making a vaginal examination, I found very little to help me. There was a normal virgin uterus in relatively good position. No mass could be detected on either side, and there was no marked tenderness at any given point in the vaginal vault. In passing the hand over the abdominal wall the sensitiveness of the left side was slightly more marked, but in the general hyperesthetic state of the woman this gave little guide as to any localized focus or point for attack.

The woman's menstrual periods had been fairly regular, some pain at each time, but not excessive in degree. It was now six weeks since she had menstruated, the flow failing to appear when last due.

Believing that such was the case, I told the attending physician that the patient had an extra-uterine pregnancy, and advised an

immediate operation for her safety and relief. In sheer desperation my diagnosis was accepted, and on the following morning she was placed on the table in a negro cabin.

The abdomen was opened in the median line. Upon introducing the exploring finger the uterus was found and normally located. The tube and ovary of the right side were free and normal. On the left side the tube and ovary were fixed to the pelvic floor, and at about the middle the tube was expanded and occupied by a gestation sac, about the size of a walnut. This was on the point of rupture, which occurred almost as soon as the fingers came in contact with its presenting surface. Accompanying the rupture, there was escape of a small quantity of watery fluid. Fearing hemorrhage, I at once enlarged the rupture opening and removed from the cavity a spongy mass entire, which proved to be a complete placenta about the size of a silver dollar, with normal uterine and fetal surfaces. No fetus was found.

Placing a silk ligature about the tube, close to the fundus, and also one near its distal extremity beyond the point of expansion, I excised the portion of tube between the ligatures. Feeling that I had accomplished my object in removing the product of conception, no attempt was made to loosen the ovary from its fixed position to the pelvic floor.

Inspection of the portion of tube removed confirmed the feel it had given to the fingers, viz., that it was an expanded Fallopian tube, having harbored a gestation sac and being on the point of rupture.

Being in some doubt as to the perfect toilet of the operation, and for the sake of safety, a gauze wick was carried down to the site of removal and brought out at the lower portion of the incision. Above this point the abdomen was closed, with interrupted through-and-through silkworm gut stitches.

The gauze was removed after twenty-four hours, and from this time on granulation was rapid and healthy. The upper portion of the wound united by first intention, the stitches being removed on the tenth day. The patient's recovery, with immediate relief of distressing symptoms, was practically uneventful.

This case seems to me to be of interest for several reasons:

Thus the gestation could not have been more than six weeks advanced, and up to the time of writing this, I had seen no report of so early a case. Again, the diagnosis was necessarily made from the rational signs only, guided chiefly by the *recurrent and paroxysmal* character of the pains, which were exaggerated, no doubt, because of the erratic location of the gestation sac. Finally, this case leads us to believe that it is an *inherent power of the ovum*, and not the peculiar structure of the uterine walls which causes the *normal, rhythmic contractions* of pregnancy and childbirth.

The second case was a much simpler one, inasmuch as the diagnosis, at the time of my visit, was comparatively easy. The patient was white and about thirty-five years of age. She had given birth to seven children, and at the time of this accident there was one child two years old, just weaned.

I was asked to see her in consultation at her home, nine miles in the country. The history given was that some weeks before, while in town, she had a sudden, severe pain in her "stomach" followed by a "fainting spell". She was given a sedative and ordered to keep quiet for a while before being taken to her home. Since that time she had, for the most part, been confined to her bed, with frequent recurrence of "fainting spells", either after or without much exertion. Having a child at the breast, the irregularities in the menstrual flow, or even its seeming absence, had given no solicitude, and she had not believed that she was pregnant.

At the time of my visit she looked as one who had lost much blood; the face was blanched, the pulse quick and thready, and the slightest exertion would cause a "fainting spell".

Upon physical examination, the abdomen was found to be somewhat full and very sensitive. Entering an ample vagina, the finger detected a uterus which had the feel of a subinvolted rather than of a pregnant one. On either side of the cervix throughout the vaginal vault there was a fullness, somewhat like that of a presenting bag of waters, although of rather more resistance; while behind the cervix, bulging well down from Douglas' pouch, and covered only by the retro-vaginal wall, was un-

mistakably either the leg or the arm of a fetus four or five months advanced.

The diagnosis of extra-uterine pregnancy being concurred in by the attending physician, the gravity of the woman's condition was explained to her and her family, and it was decided to remove her to the Twin-City Hospital. Being nine miles distant and a very rough road to travel, this was rather a serious matter for a woman almost in collapse. However, with stimulants and careful driving, it was accomplished, the patient reaching the hospital in safety. Although it was near midnight, no time was lost in preparing her for operation.

With a pair of long, half-curved and sharp-pointed scissors the vaginal vault was punctured just behind the cervix, and just where could be felt the presenting part of the fetus. Introducing the fingers of the left hand and exchanging the sharp for blunt-pointed scissors, this opening was rapidly enlarged to each lateral wall. To grasp its lower extremities and deliver the five months' fetus through this opening was a very quick and simple matter, and one that was accompanied by an immense gush of black fluid blood and clots. The quantity of this I am afraid to estimate, but it was very large, being the accumulation of several weeks' hemorrhage.

Being told that the patient had no pulse, I asked that she be given some salt solution, and working as rapidly as possible, by passing my hand well up into the cavity, which was on the right side of the uterus, I emptied it of blood clots and cleared away as much of the placental growth as seemed consistent with the safety of the structures to which it was attached.

The flow of black blood was really alarming, and several times the patient was thought to be dead; but I irrigated the cavity with several gallons of hot saline solution and, finally, by using very long and rather heavy wicks and carrying them high up, I packed it pretty full of gauze. She was taken from the table breathing occasionally and with a very feeble pulse.

For several days and nights after this it was a case of anxious watching and waiting, as the thread of life had been stretched to a very small filament indeed. Stimulants were given constantly,

and the cavity was irrigated once or twice in each twenty-four hours with several gallons of hot normal saline solution, until at last the glimmer of hope on the faces of the faithful nurses who had given me their help was also shared by me.

A most interesting feature in the after care of this case was the sympathetic involution of the uterus, as this process progressed in the neighboring structures where the gestation had occurred.

Beginning soon after the removal of the fetus, at each irrigation there would be quite a free and pinkish flow, just like the normal lochia, from the mouth of the uterus. This continued for about ten days, gradually lessening in quantity, and finally bringing away shreds like cast-off mucous membrane. During this time the entire uterus diminished much in size and the cervix lost its full, congested appearance.

The recovery of this patient was very slow and tedious, but after five weeks in the hospital she returned to her home in pretty good condition. Within the eighteen months following this accident she conceived, and carried a normal pregnancy to the seventh month, and from that time her health has been most excellent.

This case is an exception to the rule that ectopic gestation occurs either in women who have never borne children, or that its occurrence is preceded by a prolonged period of sterility. It also seems of interest because of the unmistakable history, which, coupled with the physical examination at the time of my visit, made the diagnosis comparatively easy, and also made us feel very sure that, in spite of her condition being almost one of extreme collapse, operation was the only available means for the safety of the patient.

Removing the fetus through the vaginal vault was not the method of choice, but the patient was *in extremis*, and this seemed really the quickest way and the one which nature had pointed out for her relief.

Going in from above and making a clean removal of the ruptured tube, with safe ligation of all bleeding vessels, would have been a much more complete operation, lessened the subsequent

dangers, and greatly hastened her convalescence, provided she could have survived the more prolonged tax on her vitality. This was the question confronting me, and while I did not favor the vaginal route, I felt that I must defend not only a principle and a preference, but the life of my patient as well.

Since the report of these cases and in later years I have had a number of cases of ectopic gestation, all of which were operated on through an abdominal incision, and the subsequent histories of almost all have been satisfactory.

Two, however, were of unusual interest—one of these because of a recurrence in the opposite tube within a few years. In this case I was severely reproached by the patient for not completing my work at the former operation. The other one ended in a double tragedy. The mother had gone some weeks beyond full term, when I removed a fine, living boy from the abdominal cavity. He was handed over to the nurse, but lived only a short time. As the placental growth was deep and extensive, after weighing well the risks, I determined to attempt its removal rather than to subject her to the dangers of sloughing and infection; but the shock and the hemorrhage were too great, and the end came before she was removed from the table.—*International Journal of Surgery*.

Extracts from Home and Foreign Journals.

SURGICAL

THE PFANNENSTIEL INCISION.

Dr. M. v. Holst (*Münch. med. Wochensch.*, No. 17, 1912) is strongly convinced of the value of the transverse fascial incision of Pfannenstiel in abdominal surgery. Up to the close of 1911 he employed this method in 450 cases. Of these 250 were later examined and it was found that hernia occurred in none of those healing by primary union and in only 1 per cent of those healing by granulation. Such a result had not been previously obtained with any other method of opening the abdomen. The objection made against this method, that it does not permit of a good view of the field of operation, was not found to be justified; in fact, the contrary obtained. It was found possible to remove tumors as large as a man's head without any special difficulty. One of the important advantages is that the intestines are not likely to protrude, and therefore are not exposed to drying, cooling or contact. In closing the abdominal incision the peritoneum is united with a running suture of iodine catgut and the recti with iodine catgut button sutures, while the external wound is closed with thin silk button sutures. This method permits the patient to get up early after operation, usually on the fourth day.—*International Journal of Surgery*.

POSTURAL PROPHYLAXIS OF POSTOPERATIVE COMPLICATIONS.

Wagner protests against waiting for complications to develop before raising the patient's shoulders. He thinks this should be done systematically after all major operations, whether done with general or local anesthesia. He generally raises the head of the bed four to sixteen inches and he has not lost a patient from post-operative pneumonia since he has been doing this. Children are

particularly grateful for being allowed to partly sit up, and young and old benefit alike. He raises the foot of the bed when there has been much loss of blood, and states that nothing else has such a marked influence in bringing the pulse up, sometimes accomplishing this when stimulants and infusion have all failed. In case of postoperative paresis of the bowel, turning the patient from his back on his side will often work wonders. A change of position is also often of supreme benefit in case of dilatation of the stomach and distention with air. The foot or head of the bed can be raised with the patient lying prone. This proved particularly effectual for a large abscess in the mediastinum. The abscess was drained and it promptly healed as the patient lay on his stomach with the foot of the bed raised. In no other position would it have been possible to prevent the spread of the pus inside.—*The Journal of the American Medical Association*.

DISINFECTION BY IODIN.

The antiseptic preparation of an operative site with tincture of iodine has become so much the fashion that any little hint relating to its successful application must prove useful to many of our readers. An argument against the method is the irritation produced, ordinarily slight, it is true, but sometimes very pronounced, occasionally and unexpectedly serious.

The preventive consists in applying to the painted region a 5 per cent solution of hyposulphite of sodium. After the application of iodine, the surface is covered with a layer of absorbent cotton, and about five minutes later the cotton is soaked with the sulphite solution, warmed to about 104°. The iodine is changed to iodide of sodium by the solution, which removes the irritation, and, being itself practically a physiologic solution, it is painless even to wounds or to tissues other than the skin.

The idea is to be credited to Prof. L. Sabbatini, of the University of Padua.

It is both simple and efficient in practice.—*New Orleans Medical and Surgical Journal*.

THE PATHOGENESIS, ANATOMY AND CURE OF PROLAPSE
OF THE RECTUM.

(Alexis V. Moschcowitz, Surgery, Gynecology and Obstetrics, July, 1912.)—Prolapse of the rectum, according to Moschcowitz, is in every essential a hernia. Only from this viewpoint can an intelligent method of cure be arrived at. The ordinary methods invariably fail because they do not take into account the correct pathological and anatomic conditions. The transversalis fascia is the important factor, as it is in the formation of any hernia. The pelvic part of the transversalis fascia sends an outward prolongation upon the rectum, upon which it gradually becomes lost. Increase in abdominal pressure, such as straining (secondary to heavy work, parturition, habitual constipation, coughing, phimosis, vesical calculi, stricture of the urethra, etc.), which will drive the peritoneum into the sheath formed by the outward prolongation of the transversalis or pelvic fascia, is the exciting cause of the acquired form of prolapse of the rectum. The author does not deny, however, that there may be, as in other hernia, also a congenital variety. The peritoneum, covering the anterior surface of the rectum, is intimately adherent to it, which accounts for the fact that in the prolapse of the rectum, although a true hernia, we do not find a distinct and separable sac. In other words, the hernia is exactly analogous to the so-called "hernie par glissement." The correct treatment is an operation in which the principles of an operation for the cure of a hernia can be carried out. This the author has devised and performed on eight cases during a period of six years. The technic is, briefly, as follows: Median abdominal incision with the patient in the Trendelenburg posture. The rectum is pulled up and held taut. Pagenstecher or silk sutures are then passed circularly around the culdesac of Douglas, beginning below at a point one inch above the inferior extremity of the cul de sac (and the Douglas may be found surprisingly deep in some cases). Similar sutures, six to eight in number, are passes at intervals, and persisted in as long as the peritoneum comes together until practically the entire pouch of Douglas is obliterated. In the female several of the sutures may

be anchored to the supra-vaginal portion of the cervix and body of the uterus. When approaching the rectum, the sutures coming from the sides of the pelvis, catch the serosa covering it in firm and close stitches. This is done to prevent the possible formation of a hernia; in addition these lateral sutures also materially aid in fixing the rectum to the sacrum and coccyx. The uterus and internal iliac vessels should be guarded against injury. The after treatment is practically that of any laparotomy. Morschewitz has had ideal results in the eight cases operated by him.—*The Medical Fortnightly*.

INTRAPERITONEAL APPLICATION OF CAMPHOR OIL.

Hirschol first mentions the current interest shown by gynecologists on this subject. Through multifold administration, improvements, etc., excrescences have developed upon the original idea which threatens to lead to its abolition. The author is convinced from his own experience of the excellence of this resource. In 1907 he recommended the 1 per cent camphor oil in actual peritonitis upon the theory that the oil sealed up the lymphatic openings and thereby prevented the absorption of toxins. He is not shaken in his conviction by the adverse criticism. The peritoneal cavity is mopped clean of pus with gauze strips, the oil applied throughout and the abdomen closed down to the drainage tube. The amount of oil used may reach 200 or 300 c.m., but quite a percentage of this escapes before the abdomen is closed. The actual quantity of camphor in the oil is about 2.5 grams at the most. The camphor acts as an analeptic, and it is no longer necessary to inject it subcutaneously after operating. Nothing could be gained by increasing the amount of camphor. Hoehne and others, however, have used as high as 10 per cent camphor oil in the belief that a reactive peritonitis is set up with destruction of bacteria. No toxic consequences have been noted, but delicate subjects have exhibited pallor, sweating, and even fainting. For this reason a return to weak concentrations has been urged, and none too soon, for very recently a death has been attributed to the 10 per cent oil. The ability on the part of the oil of prevent-

ing adhesions has not been insisted on, but that it sometimes has this effect seems certain. Since these cases of peritonitis may end fatally autopsy evidences are forthcoming, and the author has thus been able to convince himself that the oil may prevent the adhesions. The fallacy of assuming that oil or any other influence can prevent adhesions is apparent in the fact that the latter do not always form if the case is left to itself. Quite recently Novak has sought through results of animal experiment to show that the oil prevents adhesions, but the opposite conclusion was forced upon him. Novak sought to eliminate the peritoneum by leaving the cavity denuded to a considerable extent, but adhesions still developed.—*Medical Record*.

OBSTETRICAL

CONSTRUCTION OF AN ARTIFICIAL VAGINA FROM SMALL INTESTINES.

In *Weiner Med. Wochensch.* No. 49, Dr. Halban is reported to have constructed an artificial vagina from small intestine. After performing laparotomy he incised the peritoneal fold between the bladder and the rectum and then separated the bladder from the rectum as far up as the vaginal *cul de sac*. He then excluded a section of the small intestine and united the central and peripheral portions of the gut by lateral anastomosis. Then he implanted the excluded intestinal segment into the vulva and sutured the incised peritoneal fold leaving an opening for the passage of the mesentery of the implanted segment of gut. Lastly he enlarged the vaginal opening and sutured the gut into position. The operation proved a success from a functional point of view.—*Buffalo Medical Journal*.

OPERATIVE TREATMENT OF POSTPARTUM HEMORRHAGES.

Dr. E. Kehrer (*Münch. med. Wochens.*, No. 16, 1912) in a case of severe atonic hemorrhage successfully employed the fol-

lowing procedure: The abdominal cavity was opened by a short longitudinal incision and the uterus drawn out. An assistant quickly constricting with the hands the isthmus region and the uterine and spermatic arteries, a double silk thread was inserted first on one side and then on the other from below upwards through the fascia, parietal peritoneum near the upper angle of the wound, and the parietal peritoneum and fascia in the lower portion of the abdominal incision. By tying this double thread the round ligaments, uterine vessels, lateral portion of the cervix, infundibulo-pelvic ligaments and spermatic vessels were secured, while all the lateral vessels of the internal genitals were ligated with a thick ligature. By means of a third and fourth suture at the lower and upper angles of the wound the anterior and posterior wall of the cervix was fixed to the peritoneum and fascia, except a small place which later was closed with catgut. The fundus was removed with Paquelin or knife, and the cutaneous incision closed by the application of Michel's clamps. The operation could be quickly done, only three minutes being consumed in applying the lateral ligatures and only ten in the entire procedure. During the abdominal incision the median basilic vein was exposed by an assistant, and immediately after ligation of the two lateral uterine ligaments an intravenous saline infusion of about 1,000 v.cm., with addition of 0.4 synthetic suprarenin, was given.—*International Journal of Surgery*.

BERBERINE IN FEEBLE LABOR PAINS.

On page 21 of No. 3, Volume IV, of *Helpful Hints for the Busy Doctor*, is a report of the use of berberine in feeble labor-pains, and a request for other reports. I give the following:

I was called at 4 p.m. to see Mrs. G., age 24, mother of one child, who had been bothered with slow, ineffective labor-pains for about ten hours. At 4:30 I ordered the nurse to give two granules of 1-6 grain berberine hydrochloride each, or 1-3 grain. This was followed in 15 minutes by another dose of the same size, and a third twenty minutes after the second. There was no need for another, and at six o'clock we have a fine nine-pound boy.

The story is not through yet, for, as I took hold of the uterus to aid in getting the placenta, I found it hard. The rush of blood following the delivery of the placenta, which is so often seen, was not present and there was no subsequent bleeding. On the tenth day the patient was up and in the best of condition. I can imagine a case where too violent contraction might be of a disastrous nature, but I expect to use berberine in all labor cases henceforth and govern the dose by the case.—*The American Journal of Clinical Medicine*.

METRRORRHAGIA DUE TO ATHEROMA OF THE UTERINE VESSELS.

Metrorrhagia is essentially a symptoms of some pathologic condition, either general or local. One should determine the pathology, then apply treatment. The routine curetting of all cases, regardless of pathology, without the most careful examination of the scrapings, is to be deprecated. Many cases of suspected malignant disease are found on operation to be cases of sclerosis of the uterine vessels. Patients are usually nearing the climacteric, when we may be on the lookout for malignant diseases; or their general arterial system may give evidences of early arterial changes. That we do find definite changes with hardening of the uterine vessels both grossly and microscopically is a fact. That this change is, strictly speaking, a sclerosis rather than a true atheroma is shown by microscopic findings. Medication internally or topically is of no avail. Hysterectomy is the only rational treatment, and that should be performed as soon as the diagnosis is made and before the uterine vessels have become so brittle that ligating is unsafe.—*The Journal of the American Medical Association*.

TREATMENT OF UTERINE HEMORRHAGE.

Whitehouse remarks that in the treatment of uterine hemorrhage, the first consideration is proper diagnosis, and individual treatment will depend on the conditions revealed. Where the

bleeding is due to a high arterial pressure, the tension must be reduced by means of purgation, nitroglycerin and dieting. Purgation will also be found of value in depletion of portal circulation where hemorrhage results from hepatic cirrhosis. Should the calcium index be low, menorrhagia will be helped by the administration of this agent, preferably in the form of a lactate. Intrauterine applications, such as hydrogen peroxide and protargol, have given good results in cases of bacterial infections. Treatment in these cases must be long and thorough.—*Pacific Medical Journal*.

SEVERE GESTATION TOXICOSES.

Freund reports four cases of severe toxemia at the close of gestation, the latter having been uneventful throughout. Two patients had manifest eclampsia, the cases ending fatally. In a third fatal case the cause of death is given as latent eclampsia. The fourth patient recovered and had no cerebral symptoms at any time. Not only this patient, but two of the others presented the picture of severe hemolytic icterus. In all the fatal cases there was acute hemorrhagic diathesis. The infant in the recovered case was born with evidences of a toxemia, notably prolonged somnolence, but eventually rallied. The author is an adherent of the unicentric view, which assigns the morbidity of pregnancy to one single cause or cause nexis. Attempts to estimate the severity of the toxemia *intra vitam* by urinary studies are unsatisfactory. Autopsies alone throw light on these cases, and even then, owing to the great number of fets, the evolution of the malady can not be fully traced. A diagnosis of latent eclampsia is hardly justifiable without autopsy. If we then find all the lesions of manifest eclampsia present the diagnosis is warranted. Authors have erred at times, says Freund, in representing severe toxemias as something apart from eclampsia, when the latter was merely latent clinically. The writer has nothing to say of those fatal toxemias which occur early in pregnancy, in which a diagnosis of latent eclampsia would be absurd. On the other hand, all toxemias at term would necessarily be regarded on all sides as eclampsia in character.—*Medical Record*.

MEDICAL

TREATMENT OF ARTERIOSCLEROSIS.

Hochhaus mentions the frequent inherited tendency to this affection and also its dependence on a number of individual factors. The earliest symptoms often appear when it is too late to arrest the disease. All the possible causal moments must be eliminated one after another, as the excessive use of alcohol, tobacco, and coffee. Physical or mental over-effort must be offset by rest, work being restricted in duration and intensity. The ideal state to be attained is one of quiet activity. The patients are naturally excitable, and this should not be aggravated by worry or foreboding. The question of diet is a vexed one and the best course is to avoid any kind of extremes. This applies also to the ingestion of fluids. As a rule, this should amount to 1500 c.c. As for drugs, there are no specifics, but iodine approximates one. It unburdens the circulation in some unknown manner. Nothing is gained by giving large doses. The value of the nitrites and nitrates is questionable because they are not really indicated. The author does not believe that it is necessary to lower the blood pressure save on special occasions. The balance of the treatment is chiefly hygienic, comprising hydrotherapy, massage, etc. Many indications are not due to the disease, *per se*, but to its complications, as nephritis. The high-tension current is not even mentioned.—*Medical Record*. t.

DIAGNOSIS OF DUODENAL ULCER.

As a general rule it may be stated, says Herschel, that the symptoms of duodenal ulcer are those which were formerly at first called acid dyspepsia, and more recently hyperchlorhydria. The writer thinks, however, that we are not justified in the assertion recently made by Monyihan, of Leeds, in a monograph upon duodenal ulcer that "persistent hyperchlorhydria is the medical term for the surgical condition duodenal ulcer. We undoubtedly find symptoms, which in practice can not be distin-

guished from those of duodenal ulcer, in chronic gall-stone disease, and in chronic appendicitis; and there are most certainly both a condition of hyperchlorhydria due to proliferative gastritis and also one which is a purely nervous condition. Nevertheless, the fact remains, and this is as far as the writer thinks we are justified in going, that there is a group of different affections comprising those enumerated above which are characterized by the symptom-complex to which stomach specialists for the last ten years have given the name of hyperchlorhydria, and that of these duodenal ulcer is by the far the commonest.—*New Orleans Medical and Surgical Journal*.

IS CANCER CONTAGIOUS?

Gaston Odin, of Paris, recently declared that he had solved the mystery of cancer by discovering its microbe.

Doctor Odin's discovery is vouched for as authentic by Professor Matruchol, head of the cryptogamic botany section of Sorbonne University, and is hailed by Professor Lannois of the School of Medicine as a remarkable discovery.

Doctor Odin says he not only found, but succeeded in isolating and cultivating the microbe, which is a blood microbe. It is a parasitical organism, transforming, developing and reproducing itself in a variety of forms passing imagination. No pronouncement on the discovery has yet been made by the medical profession generally, pending the receipt of further details, but Doctor Odin is confident a serum he has prepared will do for cancer what Jenner's vaccine has done for smallpox.

One of the most startling statements made by Doctor Odin is a warning against contact with cancerous people, saying cancer is as infectious as any other microbe disease.—*Pacific Medical Journal*.

DIET IN BILIOUSNESS.

Fenwick remarks, in *The Practitioner*, that there are two principal complaints to which the term biliousness is commonly ap-

plied, the first of which is characterized by the irregular recurrence of certain gastric phenomena designated "a bilious attack," while in the second a complex form of dyspepsia, accompanied by a deficient excretion of bile, is popularly referred to as "chronic biliousness." In the treatment he says that the diminished functional activity of the biliary and pancreatic secretion necessitates the careful selection of a dietary. Excess of starchy material should be omitted in favor of partially predigested cereals and sugars, and, consequently, toast is to be preferred to bread, and the various pancreatized and malted foods to oatmeal, tapioca or sago. Potatoes do not disagree during the earlier stages of the complaint, but uncooked green vegetables and fruits always produce flatulence. Owing to the usual existence of hyperchlorhydria, milk is readily digested when diluted with lime water, and from two to three pints may be allowed during the twenty-four hours. Cream is often distasteful, and fresh butter may be digested with difficulty. Lightly roasted beef and mutton may be allowed once a day, while pigeon, chicken, game, white fish, tripe, sheep's brains and sweetbreads are good substitutes for the less digestible forms of butcher's meat. Veal, pork, and meat fat must be avoided, and bacon and ham be tried with caution. Eggs are particularly injurious in many cases.—*The Medical Brief*.

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at \$1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

ENLIGHTENMENT OF THE PUBLIC AS A MEANS OF CONTROLLING THE MILK SUPPLY.

We notice in the Lexington Leader, which paper is published at Lexington, Ky., something which was new to us, though it may be old to others. However that may be, it struck us as an excellent means of improving the milk supply in any city. It was nothing more nor less than the publication—statistical wise—of the relative numbers of bacteria per cubic millimeter of milk in samples taken over a given period of time from the local dairies. These statistics were arranged in table form so that a mere glance would tell the reader which dairies were supplying the best milk so far as bacteria were concerned. It struck us that similar tables could be published by local health officers which would show on different days not only the bacterial counts in the milk from different dairies but also the proportion of cream in whole milk, cream in milk, fat in cream, solids in milk and in short, all features of good and bad dairy supplies. Such tables published weekly in the daily papers with the dairymen's names opposite the tell-tale black line would do much toward improving the dairy supply.

Some such measure is highly desirable in the towns and cities of Tennessee, where, unfortunately, for the welfare of the people the dairymen have a combine with attorneys and money enough behind it to fight any measure which promises to cause them more expense and trouble. The average milk supply in Nashville at any rate is far from being good, and we imagine it is little better in the other cities in the same State.

If the health officers in the different cities had these statistical tables published in the daily papers we feel that public opinion would soon rectify an evil which so far has almost entirely eluded legislation.

W. T. B.

SPANISH MEDICAL COURT OF HONOR.

The Berlin Medical Court of Honor has long been in existence and its findings watched with interest. It now develops that there is one in Spain. Not long since a Doctor in Barcelona published a book which gave offense to his fellow practitioners. They promptly met together in the capacity of a "college" and decided that the publication of the book constituted a case of infamous conduct in a professional respect and sentenced the writer to be public reprimanded. The author, however, did not submit tamely to this procedure and appealed to the civil court, which revoked the sentence and gave judgment in favor of the accused. The "college" then appealed to the Supreme Court, claiming that it was a court of honor and independent of the provincial court of law. The Supreme Court promptly decided in favor of the "college", which was declared to possess the power of controlling its own professional members. Though entirely ignorant of the crime committed by the publisher not having seen what was written it is satisfactory that the "college" has the power to act as a professional court of honor in dealing with its own members independently of the courts of law.—*E. S. McK.*

ETIQUETTE ESSENTIAL IN MEDICINE.

An interesting case was up before the last Bedford Assizes. It was a case of supersession. The superceded medical man wrote the other a letter to the effect that in consequence of the others (plaintiff) conduct his colleagues would refuse to meet him, and that as such an allegation constituted an attack upon him in respect to his occupation, it justified, unless a well founded, more than nominal damages. Plaintiff was awarded fifty pounds damages. The case brings up the question, what should a practitioner

do when called in to attend a patient in an emergency or in the commencement of a new case whose name is on the books of another practitioner. On the behalf of the plaintiff it was argued that the rule is for the succeeding practitioner, as soon as the immediate need of his services are over to suggest to the patient his retirement in favor of the former medical attendant, but that if the patient requested him to remain in charge he is at liberty to do so, and need take no further step in the matter. On behalf of the defendant it was argued that though a medical man is at liberty to attend the patient of another medical man if the patient definitely asks him to do so, yet he should not only suggest retirement but should write the superceded practitioner explaining the circumstances.—*E. S. McK.*

SUMMER AT SITKA.

Sitka, the quaint old Russian capital of Alaska, was the site of a pleasant summer season by the writer quite recently. This is a town of eleven hundred persons, eight hundred of whom are Indians. It is on Baranoff Island and situated west of Southeastern Alaska. It thus receives the full benefit of the modifying influence of the Japanese current. The temperature in the winter rarely reaches zero. The weather is cloudy and the rainfall is heavy. Were it not for this much more garden truck could be raised. However, some such as cabbage, potatoes, cauliflower, red raspberries and cherries were ripened on the bush and tree as late as September 1. The Sheldon-Jackson School is a large and well supplied establishment for the native Indians situated at Sitka. It was started by the man it is named for, who was later Commissioner of Education for Alaska. It is doing an excellent work. There is a hospital connected with this institution which, strange to say, has not had one patient in its twenty beds for over a year. The medical care of the city and school is in the care of Dr. Johnson and Nurse Gibson. With cheaper and more frequent boats, better and more numerous hotels, there is no reason why the beautifully scenery and the delightful and healthful summer climate of Alaska might not be enjoyed by many more.—*E. S. McK.*

NEW YORK SKIN AND CANCER HOSPITAL,
Second Avenue, Cor. 19th St.

The Governors of the New York Skin and Cancer Hospital announce that Dr. L. Duncan Bulkley will give a fourteen series of Clinical Lectures on Diseases of the Skin, in the Out-Patient Hall of the hospital on Wednesday afternoons from October 30 to December 18, 1912, at 4:15 o'clock. The course will be free to the medical profession on the presentation of their professional cards.

CHARLES C. MARSHALL,
Chairman of Executive Committee.

AN APPEAL.

The Woman's National Wilson and Marshall Organization appeals to women everywhere for aid to carry on its propaganda on behalf of Governor Wilson's candidacy. It is endeavoring to raise \$10,000 in subscriptions of \$1 and upward. It believes that the bulk of the women of the country, like its men, honor Governor Wilson for his many achievements in New Jersey, particularly those on behalf of women and children, and see in his election the best promise of relief from intolerable tariff taxation and of freedom from boss rule. Long political experience has shown that what is best for all the people is best for any class of it, whatever special grievance that class may have. Governor Wilson's political courage, sanity and progressiveness afford the surer guarantee that the interests of women and children will find, under his presidency, their greatest recognition and advancement.

The Woman's National Wilson and Marshall organization, in addition to its other services, is assisting the Democratic organization by maintaining a Bureau of Health Conservation, of which Dr. Harvey W. Wiley is President, Professor Irving Fisher is Vice-President, and Mrs. Borden Harriman is Secretary. This Bureau is bringing before the country Governor Wilson's admirable position with respect to the protection of workers in dangerous industries, and the pure food question.

Subscriptions may be sent to Mrs. Borden Harriman, President

of the Woman's National Wilson and Marshall Organization. Room 1058, Fifth Avenue Building, New York, N. Y.

"WAR OF WEALTH AGAINST HEALTH."

Dr. Harvey W. Wiley declares the most important campaign document yet issued by the Democratic National Committee is a booklet prepared for the Woman's National Wilson and Marshall organization. It discloses some new and startling facts in connection with the long fight for pure food. It shows how the efforts of the Bureau on Pure Food were blocked by the administrations of both Roosevelt and Taft. These booklets are going to be distributed this year throughout the country by the Democratic National Committee.

In the booklet Mrs. Borden Harriman, President of the National Organization, makes a strong appeal to the women of the country in which she says:

"No subject is more vital to women than health in the home. No function is so essentially the women's function as the protection of the food supply, the protection of sanitary and hygienic working condition and the general conservation of human life. I therefore appeal to the patriotic women of America for their active participation in the present great fight which is being waged by the Wilson and Marshall campaign in behalf of these measures."

The General Federation of Women's Clubs at the biennial conference held June 26-July 6, declared that "the administration of the Department of Agriculture has been and is such that at present the law is prostituted for the benefit of the special interests and the welfare of the people is ignored," and adopted a resolution calling upon the President to "so organize the Department that the Food and Drug Act shall in the future be honestly administered in the interest of the consumers of the Nation."

The operations of the "Invisible Government" in permitting the adulterators of foods to go unprosecuted and thus protecting the interests, is reviewed, and the situation is summed up as follows:

"The law as passed by Congress was intended to be administered in the interest of the consumer. The law as modified by the executive orders of President Roosevelt and President is devoted almost exclusively to the protection of the pocketbook of the producer, showing the triumph of mercenary interests over the welfare of the public."

ASSISTANT IN EXPERIMENTAL THERAPEUTICS (MALE).

Philippine Service. October 11, 1912.

The United States Civil Service Commission announces an open competitive examination for assistant in experimental therapeutics, Philippine Service, for men only. From the register of eligibles resulting from this examination certification will be made to fill a vacancy in the position of research assistant in experimental therapeutics in the Bureau of Science, in Manila, Philippine Islands, at a salary of \$2,000 a year, and vacancies as they may occur requiring similar qualifications, unless it is found to be in the interest of the service to fill any vacancy by reinstatement, transfer, or promotion.

It will not be necessary for applicants to appear at any place for examination. Their eligibility will be determined upon the evidence furnished in connection with application and examination Form B. I. A. 2, concerning their training and the work which they have accomplished.

Applicants must be graduates in medicine, and in addition must show at least one year's postgraduate experience in conducting laboratory research work in experimental therapeutics, or, as equivalent to the year's work, they may submit copies of publications prepared by them, evidencing their ability to carry on original experimental work. A person is desired who is especially qualified in research, and it is stated that, for one who is satisfactory, the prospects of promotion are excellent.

Statements as to training, experience, and fitness are accepted subject to verification.

Applicants must have reached their eighteenth but not their fortieth birthday on the date of the examination.

The medical certificate on Form B. I. A. 2 must be executed by some medical officer in the service of the United States. Applicants should appear before medical officers of the Army, Navy, Indian, or Public Health and Marine-Hospital service. If such an officer can not be conveniently visited, a pension-examining surgeon may execute the certificate. Special arrangements have been made with pension-examining boards throughout the country to give such examination for a fee of \$2, to be paid by the applicant. This certificate must not be executed by the family physician of the applicant. The medical officer should indicate his rank or official designation on such certificate. When it is impracticable, by reason of the applicant's distance from a Government physician or a pension-examining surgeon, to have the medical certificate executed by such physician, it may be executed by any reputable physician. Such persons may be required to undergo another examination in case of appointment.

Each applicant will be required to submit with his application a photograph of himself, taken within three years, which will be filed with his papers as a means of identification. An unmounted photograph is preferred. The name and date of examination, the competitor's name, and the year in which the photograph was taken should be indicated.

This examination is open to all male citizens of the United States who comply with the requirements.

Special attention is invited to the favorable conditions in respect to transportation, leave of absence, clothing, etc., in this service, printed hereon.

Persons who comply with the requirements and desire this examination should at once apply for Form B. I. A. 2 to the United States Civil Service Commission, Washington, D. C.; the secretary of the board of examiners, postoffice, Boston, Mass., Philadelphia, Pa., Atlanta, Ga., Cincinnati, Ohio, Chicago, Ill., St. Paul, Minn., Seattle, Wash., San Francisco, Cal.; customhouse, New York, N. Y., New Orleans, La., Honolulu, Hawai; old customhouse, St. Louis, Mo.; or to the chairman of the Porto Rican Civil Service Commission, San Juan, P. R. No application will be accepted unless properly executed, including the medical certificate.

and filed with the Commission at Washington prior to the hour of closing business on October 11, 1912. In applying for this examination the exact title as given at the head of this announcement should be used in the application.

Issued September 16, 1912.

THOSE WHO DREAD ITS APPROACH.

There is this to be said to those who are dreading middle age, writes Lillie Hamilton French in the October "Century," discussing the passing of "Old Ladies," old ladyhood is really one of the most comfortable and delightful of estates. Enter it frankly with eyes open to facts, not regretting the things left behind, but rejoicing in those no man can take from you, and you will not want to be a girl again or envy your younger sisters their raiment and successes. You can be an onlooker; they never can. You have fought your battles; they have theirs to win. You have established yourself in the world's opinion; everybody doubts their stability. You know life; they are still confused by the labyrinth of its unexpected turnings.

You can have friends, unquestioned and uncriticized, a privilege denied them—friends old and young, rich and poor, men as well as women. You can dare say that you like them and still be unafraid. For the first time in your life, too, you will be nobody's rival. Jealousy, with its little sting, can not harm you.

Reviews and Book Notices

Surgical Clinics of John B. Murphy, M.D., at Mercer Hospital, Chicago. Vol. I, No. 4 (August). Octavo of 154 pages, Illustrated. Philadelphia and London. W. B. Saunders Company, 1912. Published Bi-Monthly. Price per year: Paper, \$8. Cloth, \$12. W. B. Saunders Company. Philadelphia. London.

We acknowledge with thanks to the publishers the receipt of the fourth number of the Surgical Clinics of Dr. John B. Murphy. This number is replete with practical information. As an exposition of the methods of advanced surgical work done by the distinguished surgeon it is invaluable. Among the many interesting subjects treated in this number may be mentioned the following: "Ankylosis of the Knee Joint—Arthroplasty; Joint Infection." "Nephropyloplasty;" "Traumatic Epilepsy-Decompression;" "Transplantation of Bone;" "Carcinoma of the Lip;" "Students' Clinics—Fractures." All the clinics are interesting, but these exceptionally so. The publication of these clinics in serial form is a boon to all who are not able to sit at the feet of this great American surgeon and imbibe from his spoken words some of the wisdom that has made him great. Every surgeon should subscribe to this work, as the teaching recorded here will stimulate him to greater endeavors in the field of advanced surgery of which this master mind is an able exponent.

Muscle Spasm and Degeneration In Intrathoracic Inflammations and Light Touch Palpation—By Francis Marion Pottenger, A.M., M.D., Medical Director of the Pottenger Sanitarium for Diseases of the Lungs and Throat. Monrovia, Calif. Sixteen Illustrations. St. Louis. C. V. Mosby Co., 1912.

This exceedingly interesting brochure by a recognized authority upon pulmonary tuberculosis will create a stir and widespread interest in medical circles all over the world. The author has employed the muscle spasm and muscle degeneration of the different set of muscles concerned in the respiratory acts as important factors in the makeup of a diagnosis in both early and late tuberculosis. That the muscles are affected to a perceptible extent to the palpating finger the author shows conclusively. As to

what extent this change of condition in the muscles may serve as diagnostic points in intrathoracic diseases much will depend upon the tactile sense of those who seek for these signs. Hilton demonstrated years ago in his admirable work "Rest and Pain" this anatomical fact, viz.: That the nerves that supply a joint supply the muscles that move the joint and the skin over the joint. The same association of supply doubtless rules in the respiratory act, and the author's deductions are rational and physiological. It is surely a step forward and its further development will prove of great value to the general practitioner. At any rate the work is novel in its conception and excellent in its execution.

The Blood of the Fathers—A Play in Four Acts. By G. Frank Lydston. The Riverton Press, Chicago. 1912.

Our thanks are due the publishers for a copy of this exceedingly entertaining drama by the brilliant and versatile author, Dr. G. Frank Lydston. It is really a literary gem, and dealing as it does with vital sociological problems of the day, from a medical standpoint, it should prove of instructive interest to the physician. As the author claims in his preface, it is a plea for the control and regulation of marriage, for matrimonial discrimination, for the protection of the unborn, for the sterilization of degenerates, for the under-dog, for the salvation of the young prospective criminal, for the education of the layman in matters sociological and a protest against graft in police systems and police persecution of social outcasts. It is a powerful sermon cast in dramatic form that should carry with it lessons of the greatest importance. We congratulate Dr. Lydston upon his success in a new field.

A Text-Book of Practical Therapeutics—With especial reference to the application of remedial measures to disease and their employment upon a rational basis. By Hobart Armory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Fourteenth edition. Thoroughly revised. Octavo, 984 pages, with 131 engravings, and 8-full-page colored plates. Cloth, \$4 net. Lea & Febiger, Philadelphia and New York, 1912.

The appearance of a text-book in its fourteenth edition is a most powerful indication of its popularity and usefulness. We

regard this work in its plan and execution as one of exceptional value as a text-book for students and reference work for the busy physician. The work has been carefully revised and brought fully up to date, and it is sure to maintain its hold upon the medical world as a model treatise upon therapeutics. The author recognizes, "particularly in writing this edition, that the physician at the bedside needs and desires all the help he can get, whether it comes from laboratory experience or bedside experience, and, furthermore, wants this help in a form in which he can use it when face to face with problems which are of vital importance to him and to his patients. He not only wants to know what drugs can do good but he wants to know how to use them." A new introductory chapter has been prepared and matter dealing with recent therapeutic innovations, such as salvarsan, tuberculin and vaccine therapy has been introduced with a description of Biers' method of treatment by artificial hyperaemia. The work is as nearly perfect as a text-book can be made and meets all the requirements of up-to-date medical practice.

Publisher's Department

"Paraldehyd" possesses many of the good without the evil qualities of chloral. Used in insomnia resulting from various causes. The objectional taste of the chemical is, to a great extent, disguised in Robinson's Elixir Paraldehyd (see page —, this issue) which is an elegant preparation.

THE CONTROL OF PAIN.

The work of the conscientious physician is many sided and diverse, but no part or detail of his manifold duties is ever more obligatory or imperative than the control of pain. In the presence of physical suffering any other consideration than its prompt and positive relief, with rare exception, becomes of secondary importance. But insistent and pronounced as the physician's duty al-ways is to control and assuage the pains to which human flesh is subject, it should ever be his aim to accomplish this noble purpose in the best, as well as in the quickest possible way. Other-

wise, with regard only for a patient's comfort, it is extremely liable that the agencies of relief will be attended by consequences serious in the extreme and not infrequently more harmful in effect than the original pain itself.

The foregoing has particular significance for the cautious physician, inasmuch as he has in Papine a pain-relieving measure that enables him to control pain promptly and effectively, with the least possible untoward action. Representing as it does all the anodyne properties of the most potent opiate, but with the usual objectionable features reduced to a minimum, Papine is undoubtedly the most efficient analgesic at the command of the profession. Compared with the useful opiate, Papine will be found much more free from those disagreeable effects ordinarily considered inseparable from preparations of opium, such as constipation, nausea, gastro-intestinal derangement, and tendencies toward habit formation. Thus it can be employed in a wide variety of conditions with confidence, not alone in its anodyne and sedative action, but equally in its avoidance of disagreeable or unpleasant by-effects. In brief, Papine is the ideal preparation of opium, presenting all the advantages of this well-nigh indispensable drug with its nauseating, constipating and habit-forming tendencies reduced to a minimum. Innumerable physicians use it to the exclusion of all other opiates, since it enables them to secure all of the well known benefits of the most potent opium derivative—with gratifying freedom from the usual disadvantages.

GYNECOLOGIC THERAPEUTICS.

The tremendous growth of gynecology in recent years has been confined especially to surgical therapeutics. Even Skene several years ago regretted that medical treatment of female disorders does not receive its merited attention. The practitioner is, therefore, compelled to rely chiefly on remedies which have been tested by clinicians with years of experience having the best opportunity for observation. The most frequent diseases of women are those that arise from functional disturbances of the pelvic organs. For these we call the attention of the medical profession to Dioivurnia, a combination of vegetable drugs, which has stood the test of many years as an efficient tonic and sedative to the female generative organs.

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NASHVILLE JOURNAL — OF — MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

Vol. CVI.

NOVEMBER, 1912.

No. 11.

Original Communications

INSANITY OF INEBRIETY.

By T. D. CROTHERS, M.D., Superintendent Lodge Hospital,
Hartford, Connecticut.

To call all persons who drink spirits to excess "alcoholics" is misleading. This term gives the impression that the condition present is a specific toxic state due to alcohol alone.

A study clinically often indicates that the use of spirits follows head injuries, infections fevers, shocks, sunstrokes or some distinct drain and condition of profound exhaustion; therefore it is only a symptom, which very likely increases the original condition.

The term inebriety more accurately describes some pathological condition for which alcohol is the most grateful narcotic. Here spirits are simply a symptom of some previous degeneration and diseased condition.

Clinical studies show that a very large percentage of drink and drug neurotics have had a previous history of degeneration and disease before the spirits were taken. Historically, the fact of disease was recognized long before insanity was thought to be other than spiritual madness.

The insanity of drinking men is a very old subject. The theory still exists that the early use of spirits is a moral condition, and so-called vice, and only after spirits have been used to great excess is there any possibility of disease.

A scientific study indicates the error of this theory, and that there is a distinct insanity in the use of alcohol which should be recognized. The periodic drinker, who after distinct periods of abstinence uses spirits to great excess, is undoubtedly a maniac, suffering from circular insanity.

The sudden onset and its convulsive control resembles epilepsy, and in many of the cases the relation is very close. Often the periodic drinker will have a distinct prodroma marked by insomnia, headache and great irritability and other very distinct symptoms of mental and physical change.

He does not recognize these are precursors of a drink storm, and appears to have no consciousness that they will culminate in an impulse to drink that is uncontrollable. Many persons of this class from experience recognize that these psychopathic symptoms will end in alcoholic excess.

They show a reasoning mania in provision for these attacks, arranging their business, regulating their surroundings, even when perfectly temperate and free from any impulse, knowing that the drink storm is sure to come.

It is noted that many persons are greatly exalted, up to the point of delirium in many ways at this period, or depressed, and become melancholic, then suddenly the impulse breaks out and all these symptoms pass away.

The duration of the free interval is often very exact as to time, and this resembles circular insanity. The patient's health continues good, and there are no symptoms of mental disturbance up to within a few hours of the insane impulse to drink.

The duration of the drink storm is also remarkable as to length. In many cases both the onset and duration of the drinking period can be predicted with certainty.

The startling changes of character and conduct within an hour are additional evidence of the insanity. Thus a previously moral, exemplary man, suddenly, after a few drinks of spirits, becomes a criminal, an imbecile, immoral and treacherous to the last degree. His criminality lacks continuity, and is of the impulsive, delusional character. On the subsidence of the drink craze these

peculiar symptoms disappear and he becomes a normal man in character and conduct.

The use of spirits develops delusions, hallucinations and melancholia, which subside when the paroxysm is over as quickly as it begun. Often the history of the periodic drinker indicates a marked heredity and a defective brain and nerve organization, which is increased by strains of business, predisposing the nerve energies to convulsive activity.

Another phase of insanity equally prominent and of most fascinating interest is that seen in persons who use spirits regularly, either in so-called moderation or to excess. The cumulative action of alcohol on the physical and psychic centers of the brain has not been studied very clearly.

Clinically, the steady user of spirits develops very marked symptoms of insanity. There is an exalted ego and delusions of strength in power, which, whenever practically tested, are found to be wanting. Experience and failures make no impression, but only increase a form of parietic exaltation and delusional confidence in his ability and capacity to reason and act.

Later, delusions of suspicion and want of confidence in his nearest relatives and friends, particularly the infidelity of his wife and the treachery of his children appear. His memory fails. His reasoning on matters outside of his everyday vocation is childish and simple. He becomes markedly credulous or skeptical on matters that previously did not attract his attention.

His value in positions of trust and responsibility is irregular and uncertain. He works fitfully, and when occupying a responsible position is either discharged or placed in a position where his judgments can be corrected.

Whatever opinion may be entertained by his friends or associates in the business world, he is considered irresponsible, degenerate and uncertain.

Another symptom of insanity comes into prominence in some instances. This is marked by a great failure to recognize the consciousness of right and wrong, duty and responsibility. His mentality has changed. There is feebleness, concealed delusions

and perversions of judgment manifested in conduct, varying widely from its former condition.

The sensory activity show palsy and great diminution of former acuteness. There are marked organic changes which are shown in the failure of nutrition, irregularity of the heart's action, loss of endurance and general vitality.

The modern instruments of precision can measure these abnormal conditions with great certainty. The feebleness of memory, the slowness of the mental operation, the faults of judgment and sensory discriminations and mental feebleness of reasoning with tensioned arteries and other conditions can now be mapped out with great certainty, yet many persons classed as periodic or moderate drinkers are not recognized as coming under the head of insanity.

It is literally an insanity of the paretic type with both exaltation and imbecility. At certain stages these symptoms are so marked that they can not be questioned. There is a beginning to this which escapes the attention of most observers. There is anæsthesia and diminished functions and organic shadows creeping over the mentality. The fine shadows, the uncertainties and doubts which attend all human transactions, escape the notice of a drinking man, and he imagines they do not exist. The more alcohol he uses the more positive this appears.

His condition is one of increasing anæsthesia, manifest in the rude grasp of the hand, loud voice, and exaggerations of manner as if to assure himself of the reality of his senses. He is constantly becoming more and more incapable of receiving accurate knowledge of persons or events, and the impressions he gets are imperfect, incoördinated and not accurately understood.

All these are simply the early stages of insanity. For a time he may act and reason along accustomed lines with automatic sanity, but place him in new conditions, and his mental defect and real condition will show itself.

This form of insanity is very pronounced in America, and is based on the continuous strain and drain incident to the changing conditions of the country. It is neurasthenia, fatigue and brain exhaustion. Then spirits to cover up this condition, with more

pronounced brain and nerve debility. Then follows irregular life, irregular conduct, strange reasoning, delusional and delusive activities, acute organic inflammation and death.

The last disease is supposed to be the cause of death. In reality the man was alcoholically insane, beginning from exhaustion, or perhaps with spirits, and his conduct was that of a psychopath and mental defective.

A certain small number of cases of this kind commit crime and die in prison. A large number go on to extreme stages, become demented and paretic and end their days in an insane asylum. A still larger number die from acute organic disease which comes on unexpectedly and terminates rapidly.

The public recognizes that these persons are classed among the border liners, or persons who lived in the penumbra region of insanity. The fact that they do not go on to extreme stages gives the impression that they can not be called insane according to the strict meaning of the word, and yet this is wrong.

They constitute a class of as thoroughly insane persons in many particulars as the inmates of insane hospitals. There can be no doubt that the anæsthetic effect of alcohol gives certain form and direction to this condition, which is not yet recognized in medical circles.

Medicolegally, it is a question of the highest practical interest, and the effort to mark out boundary lines between sanity and insanity results in great confusion and positive errors. Thousands of these insane people are punished by death and imprisonment for life, simply through ignorance to recognize the real conditions.

There is no subject more intensely practical for the medical man, and no field calling for exact grouping of the facts and the laws which govern their rise and progress, than this: the insanity of inebriety.

SYPHILIS IN GYNECOLOGY.

By E. S. McKee, M.D., Cincinnati; Gynecologist to the
Cincinnati Polyclinic.

The initial lesion of syphilis is found most frequently on the vulva. About thirty per cent occurring on the labia majora. Next most frequent is the introitus near the meatus and nymphæ; then the fourchette, and lastly, the clitoris. The vagina is rarely the site of the initial lesion. The posterior lip of the cervix is not infrequently the site of the initial chancre. This is sufficiently frequent and dangerous to the examining physician to make it wise for him to wear rubber gloves; indeed, a gynecologist more than any other specialist is liable to the professional contraction of syphilis. This is due to the hidden locations of the chancres. Statistics shows that 5 per cent of cases of syphilis are of nonvenereal origin. Syphilitic infection may be carried by the semen is admitted, hence we must allow the rare possibility of a chancre in the body of the uterus or even the Fallopian tubes.

The labia majora, one or both, may be the seat of gummatous changes late in syphilis. This is generally an indolent affection and often confused with elephantiasis of the labium. Occasionally the ostium vaginæ is converted into a vast gummatous mass, including the vestibulum and urethra. Gummatous ovaries are often changed into a cicatricial mass rendering the patient sterile. It is often necessary to differentiate chancre of the vulva from ulcer, chancroid ulcer, cancer, tuberculous ulcer and lupus. The finding of the spirocheta pallida makes the diagnosis absolute. This is also the positive means of diagnosing cancer of the cervix. Syphilitic ulcers are often mistaken for cancer. The history of syphilis, the prompt response to acute syphilitic treatment and the microscopic examination, will serve to render the diagnosis plain. Condylomata of the vulva are auto-inoculate and spread onto the mons.

Syphilides, especially mucous patches, are frequently found upon the vulva and down over the perineum and anus, and even

the thighs. They sometimes become confluent and form large cauliflower masses of excrescences like carcinoma. They are apt to bleed surprisingly.

Syphilitic endometritis is not very pronounced and not very well understood, especially in the non-impregnated uterus. Syphilis attacks the pregnant uterus in an aggressive manner, producing changes in the placenta and decidua which are the frequent cause of abortions and miscarriages. Endometritis is sometimes due to an irruption of syphilitic germs upon the endometrium. Bouebard and Lepine report a case of syphilitic salpingitis.

Investigations of an exhaustive nature shows that 80 per cent of women suffering from syphilis are loose women. The other 20 per cent are respectable women. These statistics are gathered by Fournier and agreed to by Ricord. Statistics also show that 5 per cent of cases of syphilis are of non-venereal origin. This should be remembered by those who think syphilis a monopoly of debauchery. For the benefit of these 20 per cent of innocent women, if not for the others, syphilis should be controlled and prevented. A married, virtuous woman may be affected by a husband suffering from ante or post nuptial syphilis or through a fetus.

Wetnursing of syphilitic children by healthy nurses or healthy children by syphilitic nurses, is a great question, and calls for much bravery on the part of the physician. Whole families have been infected in this manner. It is better that a syphilitic child should die than that a healthy wet nurse should be infected.

Pregnancy may occur in a healthy mother from a syphilitic husband one or more times without infecting the mother, but is highly improbable. In some cases of abortion, due to syphilis in the father, the mother, even though she shows no symptoms of syphilis, will give the Wasserman reaction.

Proceedings of Societies

THE ACADEMY OF MEDICINE, CINCINNATI, O.

SELECTION ON SPECIALTIES.

Paper—"The Necessity for Public Prophylaxis Against Venereal Disease"—Illustrated by lantern slides.—Dr. August Ravogli.

An invitation has been extended to a number of municipal officials to whom discussion will be open.

NOTES.

The opening session of the Academy of Medicine was a very interesting and enthusiastic meeting. The attendance was good and the case reports would do honor to any medical society.

Dr. J. A. Thompson presented the following motion: "Moved that the Committee on Public Lectures in collaboration with the Publicity Committee of the Ohio State Medical Association be directed to immediately arrange for public meetings in as many localities as possible in Hamilton County. Besides giving instruction in the preservation of health, the speakers at these meetings shall be requested to discuss the purpose of the medical practice laws and the necessity for their preservation." Seconded and carried.

Every practitioner in the county should read the recent editorials in The Lancet-Clinic of September 14, 21 and 28, by Dr. J. A. Thompson, and they will then have a better idea as to the scope, purpose and necessity for the active campaign along the lines of Dr. Thompson's motion.

Dr. Joseph Ransohoff presented a very rare and interesting condition in a four-months-old baby—a median harelip. Dr. Ransohoff said it was the first he had ever seen among probably three or four hundred cases that he had observed during his practice.

Dr. Rufus B. Hall reported (full report in Lancet-Clinic):
(1) Case of gall-stone obstruction of the common duct; opera-

tion; recovery. (2) Multinodular uterine fibroid, with specimen. Operation presented unusual difficulties owing to the nodules filling the pelvis, making delivery difficult.

Dr. Joseph Ransohoff read the report of a gunshot wound of the abdomen necessitating multiple resection of the intestine due to extensive injury of the bowel. The bullet was of large calibre and on going through the clothing it carried with it a portion of a large safety pin, which was responsible for such extensive laceration of the gut as to necessitate resection. The man's convalescence has been stormy, but he is a trifle improved on this the fourth day after operation (city hospital).

Dr. Charles E. Caldwell then reported somewhat in detail a series of gunshot and stab wounds of the abdomen. Complete report will be published in *The Lancet-Clinic* later.

Dr. J. Ambrose Johnston reported a case and presented the specimen of panhysterectomy for carcinoma of the body of the uterus (one year's standing from history). Dr. Johnson clearly enunciated the dictum that cancer of the uterine body offers a better prognosis than cancer of the uterine cervix, and mentioned previous experiences and statistics to bear out his point. Dr. Johnston also presented the specimen of uterus (vaginal hysterectomy) removed for cancer of the cervix. White woman, aged thirty-six. Only symptom hemorrhage for one month. This he said was as early as we could hope to get these cases, yet the prognosis was much less favorable than in the previous case. Discussed by Drs. Magnus A. Tate and Rufus B. Hall. Both agreed as to the point of prognosis made by Dr. Johnston.

Dr. C. S. Rockhill reported a number of cases of tuberculosis, bringing out the clinical side of the cases and then comparing the microscopical and X-ray findings in order to corroborate or disprove the clinical diagnosis. Careful analysis was shown to be very necessary in a large number of these early chest cases. The differentiation of tuberculosis and syphilis was shown to be very difficult in one case, until he tried salvarsan, which completely cleared up the picture. No special mention was made of the value of the Wassermann test as a diagnostic measure. Dr. H. K. Dunham demonstrated a number of X-ray chest pictures taken

of the cases reported by Dr. Rockhill. Most interesting of all he showed a chest picture taken of an infant that was clear and showed excellent detail. It was taken in one-eighteenth of a second's time exposure. This brings us to where we can make the X-ray aid us in the chest diagnosis in children even though they kick and cry.

Dr. W. D. Hines reported a case of compound fracture of the forearm in a man aged thirty, which was reduced and put in plaster. X-ray taken and fracture treated by open method of plating. Good apposition was obtained and patient kept at rest for three weeks. A small pustule developed which healed. Later the plate was removed but no union had taken place. The case was then lost sight of. Dr. Haines believes that plates should be used in certain cases, but that they fail at times. Full report of this case will appear in an early issue of the official organ. Discussed by Dr. Caldwell, who said he did not think the bone plates, *per se*, were a cause of non-union, but that a rather large callus was formed where a plate was used. He thought interposition of soft structures and disturbance of nerve and blood supply was a cause. Syphilis is a questionable cause. Dr. Carother's took the ground that bone plating was rather more frequent now than it would be in the future, and that a good plaster technique would serve in most cases, but plating has a definite place in surgery. Dr. Ricketts uses mercury in most cases of fracture and believes that it has a definite value in preventing non-union. Foreign bodies are also a probable cause of non-union.

Written case reports that are to be published will be only briefly abstracted by The Bulletin.—C. T. Souther, Editor.

Monday, October 14, 1912.

SURGICAL SECTION.

Paper—"The Comparative Value of the Medical and Surgical Treatment of Puerperal Eclampsia."—Dr. E. G. Kinke.

Paper—"A Comparative Study of the Appendices and Cecæ of Vertebrates, with an Addition of Small Birds' Appendices to the Literature."—Dr. D. D. DeNeen.

NOTES.

In the absence of President Porter, Dr. J. Ambrose Johnston acted as presiding officer.

The following names were presented for application to membership and referred to the Board of Censors: Drs. E. R. Twachtman, W. C. Clark, C. Walter Manss, Chas. A. Hoeffling, J. D. Spellman.

Dr. Otto P. Geier called attention to the Municipal Exhibit now at the old St. Nicholas Hotel building, and emphasized the importance of every physician making a personal call to see the exhibit. He stated that it was well worth five hours of any man's time. It is a bit of political economy education that it would take months of careful study to acquire from any other source. It should be considered a privilege to have a chance to get so much, in so condensed a form, of the inside business working of our municipality. Dr. J. A. Johnson emphasized Dr. Geier's statements.

Dr. B. M. Ricketts presented a patient, man, thirty years old, who, while doing electrical work on power-house had his head come in contact with a feed wire which became grounded. The feed wire was carrying 33,000 volts of current. Patient fell thirty-three feet to ground and fractured arm and shoulder and burned the external soft parts of top of head and external table of skull. His feet were burned and the nails in shoe heel melted into iron plate on which he was standing. External table of skull was finally thrown off as sequestrum, and is healing over after fifteen months. Man is otherwise well.

Dr. Ben F. Eckman presented a piece of omentum removed intra-abdominally from its incarcerated position in the ruptured uterus. From the history of the case it had probably been in this unusual location nine months. Dr. Eckman said it was the second case of the kind he had seen. The other case when reported to the Academy had caused some criticism. Dr. Gillespie asked if there had been a history of previous recent abortion? Answer, no; but patient gave birth to a child nine months previous. Dr. R. B. Hall asked if patient had menstruated since confinement. Answer, no.

Dr. Ravogli's paper on "The Necessity of Public Prophylaxis of Venereal Diseases," contained many suggestions as to possible methods of dealing with this most important sociological problem. He takes the ground that segregation and examination by the health department is the best method. Men who are thoroughly competent should do the work of examining at frequent intervals, and be paid a salary sufficient that their whole time can be devoted to the work. Infected women should be sent to the hospital, and detained until they can no longer communicate the disease by sexual congress.

Dr. Edwin Shields took the ground, in discussion, that there were so many objections to the method advised by Dr. Ravogli that it was a bad thing. Why legislate against women and let the men go free? He contended that the work of examining these women as done years ago had been abused, and the chance for graft was too great with the method advised. He said members of the profession had not been fair or truthful in their reports on this work.

Dr. Gillespie believed it could be done, and had a better opinion of the profession than to think they would stoop to any such things as the previous speaker intimated.

Dr. Dunham said it could not be done here as abroad on account of this being an Anglo-Saxon race.

Dr. Heidingsfeld discussed the problem and spoke of methods in vogue in Vienna and Berlin.

Dr. Louis A. Molony spoke of the plan of having the redlight district removed to a distance from the heart of the city, and called attention to the methods in vogue in Japan.

Dr. A. W. Nelson also discussed the question of the real value of any control method, and said it was very hard to either control or estimate its value, but the protection from all contagious disease certainly was right.

Dr. Stanley Zinke said that what was necessary were laws to back up the control and then not only the women but the men should all be examined before they are allowed to cohabit with public women.

Dr. J. H. Landis discussed the problem from the standpoint of the health department and said it was very much of a question whether the method being tried in Minneapolis and Chicago were good. Cleaning out the public brothel and forcing the women into flats and respectable parts of town is a questionable procedure. He did not see why all laws pertaining to contagious disease could not be enforced against syphilis and gonorrhea. The health department had frequently discussed the problem, but had no money to carry on any control.

Dr. Walter Griess detailed the methods in vogue in German cities and in France, and presented the literature used by the department (police) to control and record the prostitute.

Monday, October 21, 1912.

MEDICAL SECTION.

Paper—"A Comparative Study of the Appendices and Cecæ of Vertebrates, with an Addition of Small Birds' Appendices to the Literature."—Dr. D. D. DeNeen.

(This paper was carried forward from the meeting of October 14 for this meeting by order of the Academy.)

Paper—"A Definition of Nervous Dyspepsia."—Dr. Henry Wald Bettmann.

NOTES.

Those who have not paid dues please remit to the treasurer, Dr. A. G. Drury, 836 Lincoln Avenue.

Dr. Oscar Behrman, 2615 Reading Road, has applied for membership.

Dr. Carothers' motion that a committee be appointed by the Chair to act as a reception committee to our distinguished guest, Mr. W. Arbuthnot Lane, of London, England, and to manage the First Councilor District Meeting, to be held in November, was seconded and carried. Dr. Porter appointed on that committee Drs. Carothers, J. Edw. Pirrung, John D. Miller, C. T. Souther and Frank Lamb.

Dr. J. W. Murphy presented a case of rhinophyma in a patient, and spoke of the method to be used in treatment. Patient

was also suffering from ectropion. Dr. Wyler had operated one eye and the other would be operated later.

Dr. Robert Sattler presented a patient with large angio-fibroma of left temporal region and another angioma on eye and side of nose. The external carotid had been tied as a preliminary measure to other operative interference. The ligating of the external carotid had caused so much improvement that further interference would probably not be necessary.

Dr. B. M. Ricketts reported five cases (to be published in *The Lancet-Clinic* later), as follows:

1. Resection of elbow joint following injury.
2. Specimen of large cystic goitre (not exophthalmic).
3. Case of large cystic goitre treated by aspiration.
4. Case of osteomyelitis in girl eight years where the hip was primarily involved and later the tibia and fibula, necessitating amputation below the knee.
5. Case where a patient fell 152 feet and recovered with a dislocated kidney, kinking of ureter and necrotic spot in kidney necessitating nephrectomy; death from shock.

Dr. E. G. Zinke presented the regular paper of the evening: "Comparative Value of Medical and Surgical Treatment of Eclampsia." The paper covered the whole field in a very careful, painstaking and scientific manner. Much data and statistics were presented, including twenty-nine cases by the author, showing the relative value of medical and surgical treatment.

Dr. B. M. Ricketts, in discussion, brought out the value of rapid work when operation was resorted to, and spoke of the inability to arrive at a reliable conclusion based on statistics, for the reason that probably many medically treated cases resulting fatally were never reported, while surgeons were more apt to record results. The uterus can be emptied very rapidly under local anæsthesia, thereby avoiding the risk of yellow atrophy that may follow a general anæsthetic.

Dr. Wm. Gillespie took the ground that surgery was not the treatment for eclampsia except in rare cases, as many cases developed after the uterus had been emptied. A study of the litera-

ture for the last sixty years would indicate that violence was not necessary. Mortality rises in proportion to the activity of the interference. Chloral, up to sixty grains per rectum and veratrum in full doses of ninety minims, was at times necessary to control a case. Convulsions precipitate labor. Treat convulsions and let the labor progress. Cæsarean section is at times justifiable.

Dr. Stineharter spoke of the methods in vogue in Russia in managing these cases, and quoted the doses of morphia, etc. He held that elimination by the use of castor oil, stomach lavage and colon lavage were essential, and quoted statistics with a mortality as low as 7 to 9 per cent.

Dr. C. C. Fihe held that we should have a more definite knowledge of what constitutes eclampsia. His experience had been discouraging, both medical and surgical means having failed. A reduction in the total output of albumen was important. Fischer's solution had failed in one case and worked well in another. Acetate of soda, ten-grain doses, with plenty of water, seemed beneficial.

Dr. Martin H. Fischer believes the assumption that it is a toxemia to be corrected, that it did not always attack the same organ. The brain might be first affected, causing a different array of symptoms. Elimination is the proper treatment, and acidosis explains certain pathological changes and symptoms that follow the onset of labor in these cases. Depending on the degree of insult to the organ, the symptoms would be mild or severe.

Dr. Stanley Zinke had examined the urine in a case for the essayist, making the phenolsulphothalein test and found a normal amount excreted in the first two hours, which would lead to the conclusion that the functional activity of the kidneys was good.

The Program Committee announces Dr. W. Arbuthnot Lane, London, for November 11; Dr. Louis Hamman, Johns Hopkins, November 18; Dr. J. H. Kassell and Dr. J. Heally, December 16. Details will appear later.

October 28, 1912.

CASE REPORT NIGHT.

Paper.—“Blood Counts and Blood Examinations.”—Dr. A. E. Osmond.

Case Reports.—(1) “A Cæsarean Operation; (2) Osteo-Sarcoma of Hyoid Bone.”—Dr. D. D. DeNeen.

Case Report with Specimen.—“Cystic Tumor at Base of Tongue.” Dr. C. T. Souther.

NOTES.

President absent. Vice President Dr. Rowe presided.

Drs. C. R. Case, Wm. C. Clark, C. Walter Manss, Charles A. Hoeffling, J. D. Spellman and Eris R. Twatchman were elected to membership.

Dr. M. L. Heidingsfeld presented a very interesting case of hereditary syphilis in whom there was an apparent initial lesion on the penis. It had all the evidences of a fresh lesion, but absolute diagnosis had not been definitely made. A second case showed marked evidences of hereditary syphilis with extensive gummatous lesions of the leg.

Dr. H. H. Hines presented a specimen of a brain containing a tumor removed post-mortem and reported the case in detail. Tumor in the posterior portion of left cerebellar lobe. This had been correctly diagnosed and a decompression operation done in March, 1912, and patient was greatly benefited. Later symptoms developed indicating that the trouble was at the sellaturcica or near hypophysis, and a second lobe operation was made on October 19, and the temporal lobe opened and region explored. Patient, however, lived only fourteen hours. (Full report will be published in the Lancet-Clinic.)

Discussed by Dr. D. T. Vail, who made the eye examination and located the tumor in the cerebellum. Dr. D. I. Wolfstein saw the case in consultation and assisted in making the diagnosis. Dr. Vail referred to the recent book by Harvey Cushing on the subject of hypophyseal tumors, and said it was the most reliable authority on this subject.

Dr. D. D. DeNeen then read the first paper of the evening—"A Comparative Study of the Appendices and Cecæ of Vertebrates, with an Addition of Small Birds' Appendices to the Literature." Dr. DeNeen's paper contained much of the comparative study of the appendix and cecæ of vertebrates, and must be read to be appreciated. The Bulletin will not try to abstract the paper, as it will be published in The Lancet-Clinic later.

Discussed by Dr. B. M. Ricketts, who complimented Dr. DeNeen on his excellent work and went over some of the anatomy of the cecal region in a number of animals.

Dr. Henry Wald Bettman—"A Definition of Nervous Dyspepsia." Dr. Bettmann's paper was brief, but carried many points of merit, which showed his ability to give this term more of a definite place in the literature. He made a plea for a better understanding of the terms already coined rather than the frequent free coinage of nomenclature in the gastro-enterological field. Full paper will appear in The Lancet-Clinic.)

Dr. Bettmann's paper was discussed by Drs. J. Henry Schroeder, B. M. Ricketts and Edwin M. Baehr.

Dr. Dunham made a motion that as Dr. A. E. Osmond had been pushed off of the Medical Section tonight, the Academy hear his paper next Monday night, October 28—case report night. Seconded and carried.

Selected Articles

TENDENCIES OF MODERN SURGERY.

Address on Surgery, delivered at the 25th annual meeting of the Medical Society of the Missouri Valley, September 5, 1912, at Council Bluffs, Ia.

HENRY T. BYFORD, M.D., Chicago, Ill.

He who would tell of the future must look into the past where it lies mirrored. He who would understand the present must look to the future and wait until it tells him what has become of the present. It would undoubtedly be pleasant and perhaps profitable for us to follow the fashion of converting the annual address on surgery into an arithmetical sum in addition by reporting the accomplishments of the past year; but I haven't the gift of prophecy to enable me to tell what in the future will be found good, and as such should be recorded, nor what will be found bad, and as such should be forgotten. What has been done since our last meeting should be tested in the future by the work of workers rather than be rated at present by the talk of talkers. I will therefore content myself with a discussion of tendencies rather than a determination of values, and will begin by taking a look into the past, hoping, by comparing it with the present, to discover the road which the practice of surgery has been traveling and the direction it is taking, and should take in the future. To this end I will recall to your mind some of the conditions that have existed within the memory of many of us.

We know that some of our preceptors obtained their medical education in the offices and on the circuits of their preceptors and procured licenses to practice upon the basis of such education. When they had practised for a longer or shorter period they were able by attending two winter terms of six or seven months each at a medical college to obtain the degree of M.D. Up to the year 1870, when I began the study of medicine, the col-

leges delivered only one course of instruction, and in order to keep the students out of mischief for two winters, required them to sit all day and listen to all of the lectures of that course in the first year and to repeat the performance in the second year without variation. Laboratory work comprised two or three hours a week for two or three weeks of qualitative analysis and blow-pipe combustion. Microscopic work consisted in looking at normal histological tissue and at a live frog's foot in the amphitheater. Physiological demonstration culminated in the opening and inspection of the abdomen of a dog in the lecture room and then killing it with chloroform.

It took the conservative professor many years to work out the problem that by attending the primary half of the course for half a day during the first winter and the senior half for half a day during the second winter the students could acquire the same amount of learning with half the sitting, and thus have time for doing something besides sitting. The quizzing was done, when it was done, during the lecture hour by the professor. The quizzing was a difficult problem for the professor, since half of the students were capable of understanding only half of what they heard, and the necessity of covering the entire field of medicine in one course of six or seven months left but little time for quizzing. They undoubtedly expected the students to pick up some crumbs of knowledge from their preceptors, and from clinics, which consisted in viewing operations from a distance and listening to didactic lectures at the bedside.

If a wise man had at that time looked forward to and planned the extended complicated and expensive system of medical education of today he would have been considered an impractical dreamer, out of touch with the times.

What I have said applies, of course, to medicine in general and largely to college work. Let us now consider some of the changes in the practice of surgery.

Fifty years ago operations were performed by preference in the patient's home in the city or country, or anywhere so not in a hospital, over which infection ever hovered like a flock of invisible vultures. Preparation of the patient, surgical nursing, after

treatment and antiseptics were in an entirely undeveloped, I might say, chaotic state. Major operations were looked forward to by the patient with terror, and the name hospital was associated in the popular mind with horrible experiences. Those who required an operation in one of the closed cavities of the body waited until death was imminent, made their will, said farewell to their friends, and seldom disappointed their heirs.

As antiseptic and aseptic methods were developed, private hospitals were fitted up in the medical centers in which the evils connected with the general hospitals were largely eliminated. Preparation for operations, antisepsis, trained nursing, personal attention of the surgeon to the after-treatment and after-operations began to tell. Surgeons began to understand the dangers, and patients began to escape them. With complete control of the patients and their surroundings and with the assistance of personally trained attendants the surgeons invaded the sacred recesses of the body with triumphant success. Under such conditions Lawson Tait accomplished marvels for the times in which he lived. Even in the general hospitals the medical staffs were placed in complete control, to the exclusion of all interference or participation of outsiders in their surgical work. Conditions were most favorable for the accomplishment of the best individual results.

Before long the operative technic of many of the major operations was perfected and the details of asepsis systematized and popularized. Post graduate schools were established by men skilled in technic and versed in asepsis, and post graduate courses were given just long enough to impart to aspiring young surgeons a dangerous amount of knowledge and a disastrous kind of confidence. General hospitals were built in the larger towns throughout the country, and postgraduate students began to do the operating in them for their communities. A postgraduate course was popularly supposed to qualify a man for a place in the front rank of surgery. As a result the major operations were no longer sent in such large numbers to men with private hospitals conducted on the closed door plan.

In large cities the general hospitals, in order to retain their patronage, had to throw open their doors to the profession and permit any physician or surgeon to perform any operation he chose to undertake, as was done in the country hospitals. The private hospitals found themselves unable to compete with the heavily endowed general hospitals under the complicated and expensive system connected with modern aseptic methods and the luxurious accommodations for the comfort of the patients and their friends, and soon had to close their doors, so that today the general bulk of major surgery is done in general hospitals. Although many specialists and older operators are working in general hospitals, a large number of men with defective training are working alongside them and are doing everything in surgery. They do the most complicated and surprising operations. And thanks to the organization by the hospital of a rigid aseptic system, their patients usually get out of the hospital alive and sometimes without serious bad results, and are effusively grateful to the operator for getting them out of the trouble they got into. And the hospitals, by serving them in the operating rooms and caring for the patients, publicly endorse their work; and the hospital authorities know not what to do.

As a result of this democratization of the practice of surgery the younger surgeons in small communities keep the work at home, and the city surgeons, seeing their occupation going, put in their spare time learning and performing the operations of the specialists. Many of the specialists, feeling the pinch, are performing the operations of general surgery. Old dogs are learning new tricks to offset the tricks of the young ones.

Competition, which nowadays is not considered the final and supreme regulator of business that it used to be, seems to be the supreme regulator of the practice of surgery. Surgeons underbid each other and patients shop for barbains. Those whose business instincts are too pronounced to be influenced by conscience compete for trade by offering or granting commissions. Physicians who have no conscience sell their cases to the highest bidder instead of seeking for the best aid obtainable. The profession has apparently joined in the procession of corrupt ex-

plotation that characterizes this commercial age, this golden age, this age in which the golden end justifies the guilty means. In saying all this I am not blaming surgeons, either individually or collectively, for doing what they have been publicly authorized to do, nor for the presence of so many black sheep in their flock. I am merely calling attention to conditions.

The progress has been from special work done by special men in special hospitals with specially trained nurses and assistants, to general work done by general men in general hospitals with generally trained nurses and assistants. The inexperienced and poorly prepared surgeon gets the benefit of working in hospitals which not only impart dignity to his deeds, but provide best facilities and enforce the best methods for work, both in operating room service and nursing, and thus not only enable him, but teach him to do better and bigger work. On the other hand the specialist and experienced surgeons have often to dispense with things that a general hospital can not provide and that he would have if he had personal control of details and the personal training of assistants, and he therefore can not do as good work as under the old system. The tendency of this generalization has been for the people to get more of the better work of the poorer surgeon and less of the best work of the trained special surgeon. On account of the competition the patient pays less for surgery, and gets less for his money.

We must surely admit that everything connected with surgical practice is not ideal, and that conditions can not go on as they are going now. But we can not return to old conditions. That would be equivalent to saying that we are going wrong, and that there is no benefit in the new. We can not give up our well conducted hospitals with the improvements that made possible their large endowments and extended patronage. Private hospitals can not provide the same facilities and are scarcely to be reckoned with. The path of progress lies not in going back to the private hospital system, but in making the facilities for the best work as good at the large hospitals as they could be in privately conducted ones. It does not lie in the direction of restricting the operating to the few but in preparing many to do it properly.

The hospitals are doing all they can. The thing most needed is a better preparation of the men who are permitted to do the work. The present tendency of the public to turn over the new and complicated operations to the young graduate or the general practitioner who has taken a sitting course of six weeks in a postgraduate school has gone too far. The interests of the public demand that there be a development in medical education that will provide the surgical training that the surgeon now gets too largely through his practice upon his patients.

Nor is it doing the surgeon justice any more than his patients that he should be called upon to diffuse his studies and scatter his experience over a field so large that he can not hope to acquire a proficiency in the diagnosis and differentiation of all of the surgical diseases and conditions connected with them, nor be able to form a reliable opinion as to operability or desirability of operating, to say nothing of the choice of operation and the adaption of methods. What the mind directs and the hand executes daily or hourly is apt to be well done. What the mind directs and the hand executes at long intervals will fall short of excellence in proportion to the infrequency of performance and to the number of other things that occupy the mind and hand in the intervals.

In condemning such general diffusion of surgical work I do not mean to recommend a stricter adherence to the specialties along the old lines. I would rather suggest that all surgeons should be prepared for their operations in the concrete sense before they are permitted to perform them publicly and independently. This would necessitate a more specialized early education of the surgeon and an individual development upon lines for which he is best adapted, or upon which he is thrown by circumstances, or toward which he directs his work by preference. If he can attain universal surgical proficiency by living long enough and without practising text-book knowledge upon unfamiliar cases, then let him do everything in surgery, but not until then.

I can not better illustrate the growing need of selection or specializing in the study of medicine than by quoting a few lines from Wm. M. Polk's article on "Medical Education in New York." (Surgery, Gynecology and Obstetrics. August, 1912,

page 8, of Clinical Congress Supplement.) Under the heading "Teaching Along New Lines" he says:

"The scope and character of the teaching along new lines is or should be a measure of the progressive aspect of teaching. We select at random a large number of the subjects which were not recognized a few years ago; hydro- and physi-therapeutics, neurological surgery, including surgery of the peripheral nerves, diseases of the circulation including the Nauheim treatment, tuberculosis and phthisiotherapy, epilepsy, diseases of old age, tumors, immunotherapy, food poisoning, psychotherapy, medical economics, physiological therapeutics, intubation, nutrition in health and disease, contagious diseases, speech defects, autopsy technique, radiology, medical physics, neuropathology, clinical physiology, experimental therapeutics, anæsthesia, neuro-anatomy, anatomy in the living, medicolegal pathology, microphotography, life insurance examination, quarantine sanitation, sanatorium treatment of tuberculosis, infant feeding, manufacture of serums and vaccines, medical society drill, proctology, radium therapy, phototherapy, hematology, history taking, cystoscopy, cystoscopy in the female, abdominal diagnosis, antepartum obstetrics, physical diagnosis of tuberculosis, infant diagnosis, lumbar puncture, histopathology of the skin, radiography of the sinuses, bronchoscopy, esophagoscopy and gastroscopy, foreign bodies in the eye, medical gynecology, surgery of hernia, cadaver courses for all the specialties (anatomy and surgery), demonstration of instruments at factories, special courses under tropical medicine (heminthology, etc.)."

This list might be supplemented by a long list of things that have been added to the student's mental burdens along old lines.

Evidently the present undergraduate course of instruction is not all it should be and will be, although the problem is being worked out as fast as funds will permit by those who have it in charge. The subject is so interesting and pressing that I will occupy a few moments in calling to mind some of the modifications and additions to our methods of teaching and licensure that might be of benefit in preparing students for better work, and for securing better surgery in practice. Among these are a fifth year

in college for practical training, an improved system of hospital interneship, practical postgraduate courses, operative and experimental courses on living animals, operative courses on the cadaver, an assistantship in a clinic or in the private practice of a surgeon, degrees or titles differing according to the character of the instruction and licenses from the state to conform to qualifications. Examinations should be more practical than at present with reference to ascertaining what the applicant can do as well as what he can recite.

In the fifth year of the medical course the student would learn the practical and technical part of diagnosis or treatment. He would have adequate instruction in laboratory diagnosis including the methods of obtaining and examining the blood, the contents of the stomach and the different excretions and secretions in health and disease; instruction in bedside diagnosis with a short but real hospital service as assistant in hospital and dispensary clinics and to hospital internes, including case-taking, the preparation and after treatment of operations at which he had assisted in some capacity, wound dressing, hypodermoclysis, intravenous medication, etc.; instruction in practical obstetrics, including antepartum and postpartum abnormalities, the use of the methods and instruments of special practice and investigation, the estimation of blood pressure, the employment of vaccines and antitoxins and other things connected with internal medicine as well as the specialties. As no man can be expert in all kinds of work such a fifth year would, I suppose, have to be largely elective and so arranged that the future surgeons could omit some of the more complicated work connected with general medicine and could select some of the special surgical work without having to take all of it. One who wished to practice a specialty on narrow lines would find in this course such practical work in general medicine as would be necessary to enable him to understand and recognize the connection between the diseases in his specialty and general conditions. At present the specialist must qualify himself in this respect by a few years of general practice or he must make up for his deficiency by frequent consultations with

those who are qualified. But there is now no way of compelling even these makeshift compensations.

With students prepared by a fifth year of specialized study, hospital internship could be developed so that the graduate might select the kind of hospital for his purpose, or the surgical or medical or special hospital services could be developed to give the interne more practical work than at present, including operating under the guidance of the attending surgeons. This should be made a part of the training that entitles him to procure a license to do certain work. The certificate or diploma from a hospital should mean more than it does now.

Operative work on the cadaver should, I think, be taught to the undergraduate for it would prepare him for operative work while serving an internship or assistantship.

Whether operative and experimental work on the living animal should be undergraduate and of limited character, or whether it should be postgraduate and extensive in its scope and with special recognition I will not attempt to discuss.

The courses in postgraduate schools might be lengthened and developed to give the students a specified amount of clinical diagnosis and operative work in minor surgery and in some of the specialties, and thus be made to count in the procuring of licenses, instead of being used, as at present, to fool the public.

To what extent the fifth year, the postgraduate courses and the special and general operative courses on the cadaver and on living animals could be made to take the place of a hospital internship, or vice versa, would be a subject for adjustment. The fifth year might be made up entirely of optional work, or be optional as a whole to those who could acquire an equivalent training in a hospital or elsewhere. The end in view would be for the college to give the young graduate a definite kind and amount of training or experience, and for the state to license him to do only what he has actually done or learned how to do. The public who trusts him and pays him has a right to this.

The conservative doctor will say that all this is too complicated to be carried out and that such restrictions are out of place in a free country. But I would remind him that the present restric-

tions that prevent men from practicing with the preparation and qualifications of fifty years ago would have seemed just as impracticable then as what I propose seems to him now. Something of the kind must come, and it should not be fifty years in coming. Fifty years ago people knew that the young medical graduate didn't know much in a practical way, and didn't allow him to hurt them; today the young men are supposed to be more modern and up-to-date than the professors who teach them. But if the public knew of the present faults of omission as well as of commission in the practice of the incipient surgeon, it would become panicky and would insist upon some such development for its own protection. The prevalence of paying commissions, of fee-splitting, of the recommendation of incompetent friends, of taking full charge of cases by those unprepared to do so, would to a great extent disappear under a proper organization of our instruction and systemization of our practice. If we can bring about such an improvement before the people demand it, and before they appoint a commission to regulate us as they regulate the railroads and the trusts, we will be doing justice to ourselves as well as our patients, rather than be giving our legislators an opportunity of doing us injustice. It is better for us to regulate ourselves, and do it right, than for our lawmakers to do it, and do it wrong.

In conclusion, let me again state that I am not trying to fix values nor suggest specific remedies, but have discussed established facts with reference to revealing tendencies and indicating the nature of needed reforms.—*The Medical Herald*.

Extracts from Home and Foreign Journals.

SURGICAL

OPERATION IN SUPPURATIVE MENINGITIS.

Kostlivy, in *Archiv für klinische Chirurgie*, reports three cases of suppurative meningitis operated upon with favorable results in two cases, and observes that the surgeon should not hesitate to perform a radical operation in any case so soon as the diagnosis of an intracranial suppurative process is manifest. It is only by early operation in these cases that the conviction can be forced upon the internist that these cases belong as much to the surgeon as does suppurative peritonitis. By operation the mortality in the most severe cases of peritonitis can be reduced 50 per cent, not to mention the number of patients in whom early operation will protect against these grave complications. Perhaps the same hope will be realized in cases of suppurative meningitis.—*The Medical Brief*.

FLAT FOOT.

Dr. B. P. Weaver (*Jour. Ind. S. M. A.*, August 15, 1912) summarizes his view in the following conclusions: 1. Weak-foot is a condition far commoner than the average practitioner may believe, and must be considered seriously before a diagnosis of rheumatism is made. 2. All weak or pronated feet do not have depressed arches by any means, but represent rather a type in which there is a relative disproportion between weight-bearing and functional support. 3. Much can be done by the family physician to relieve and overcome this condition when once properly diagnosed, and in such treatment the irrational application of a rigid plate or brace as a life term sentence, must ultimately give way to a more thorough-going course of training in the exercise of proper functional use. 4. Proper shoeing at all times and temporary support, such as by adhesive strapping, in some cases, are potent

factors in the treatment of all cases of weak-foot which do not demand operative correction.—*International Jour. of Surg.*

PERFORATION OF A POSTOPERATIVE PEPTIC ULCER OF THE
DUODENUM INTO THE TRANSVERSE COLON.

Pinner reports a case of this type, and states that it makes the tenth on record. In all of these cases the conditions were the same, viz.: the perforation followed a retrocolic gastroenterostomy. It is evidently immaterial whether the operation was done on the anterior or posterior wall of the stomach; whether or not a Murphy button or some other resource was used. The jejunal ulcer may occur after any method. The author gives a digression on the causation of peptic ulcer in the jejunum. The general assumption is that a hyperacid gastric juice is at fault, and this is no doubt the chief factor. But not in every case do we find evidences of hyperchlorhydria, and similar ulcers may occur in the normal jejunum in which only alkaline secretions are present. In such cases we have to fall back on local injuries, embolism, arteriosclerosis, etc., as possible factors. Once these ulcers form perforation into the colon is readily intelligible. Diagnosis should not be difficult in theory. After the gastroenterostomy, the entrance of colonic products into the stomach and vomited matter, as well as dysenteriform symptoms make the case a plain one. In practice, however, these symptoms may be quite lacking. In certain cases pains have constituted the sole symptom. The subject of prevention is bound up with that of diet, but authorities are not agreed as to what this should be. Naturally the continued presence of the original disease which led to the operation may demand constant attention. The only treatment proper is naturally a second operation.—*Medical Record.*

MEDICAL

IGNATIA.

William M. Gregory, in the June number of the *Medical Summary*, considers ignata the very best tonic we have. He states that ignatia fills a place that can not be filled by

nux vomica or strychnin. Besides being a cerebrospinal stimulant, it has qualities as a nerve sedative and reconstructive which make it an exceedingly valuable remedy in all weak and excitable conditions of the nervous system. It should be used in many cases where the compound syrup of the hypophosphites is usually used, and also in many disturbed conditions of the female nervous system, where bromids and chloral are generally employed. He reports cases in which its valuable tonic properties were shown, and states that it is a remedy, or, rather, one of those peculiar vegetable remedies, that will not reveal their true curative principles to chemistry. It contains a large percentage of strychnin, but its field of action differs from that of nux vomica or strychnin. Its great value lies in the fact, which should be universally known, that it is the most powerful remedy we have to allay great nervous excitement, and at the same time give the patient permanent strength and improvement. He prefers ignatia, cinchona and dilute phosphoric acid to the hypophosphites, and he recommends it after any long and exhausting illness. It is excellent in checking the night sweats of greatly exhausted patients. He also prefers the specific tinctures of ignatia and cinchona to the pharmacopeial fluid extracts.—*The Medical Brief*.

WINE AND CIDER IN GOUT.

Motais (*Bulletin de l'Academia de Medecine*, Paris, July 2, 1912, Abst. J.A.M.A.) reports eight cases of gout in which he tested the effect of wine and cider. The wine used was the red Bordeaux wine, and his conclusions are: 1. That the use, even in moderate quantities, of the red Burgundy or Bordeaux wine, while it may not produce gout in health individuals, is likely to be injurious to those predisposed to gout or who are suffering from the disease. 2. A mild cider well made, but not too hard, prevents gout; combined with rational diet and exercise, it becomes a genuine therapeutic agent, diminishing or even reducing the frequency and intensity of the attacks. 3. The attention of therapeutists should be drawn to the action of cider in gouty affections of the eye. 4. While without doubt the pathogeny of arthritic

affections is variable, and such conditions may not apply to all cases of the disease, yet the author believes that cider should not be merely allowed to gouty patients, but should be prescribed to the majority as a habitual, perhaps exclusive beverage.—*The American Practitioner*.

ESSENTIAL HEMATURIA.

Nelken, in the *American Journal of Urology*, believes essential or "idiopathic" hematuria to be due to some form of chronic nephritis. The cases are usually treated for stone, tuberculosis or cancer of the kidney. The lesion may, as in Albarran's case, be only as large as a millet seed. Unilateral nephritis may be the cause of the bleeding or the latter may come from one kidney in a case of bilateral nephritis. Casts and albumen are not essential in the finding of a nephritis; the presence of blood alone may be the only indication of the nephritis. A number of cases clear up without treatment. Others yield to irrigations of kidney pelvis with adrenalin chloride or nitrate of silver solutions. Decapsulation is often effectual, while some cases will yield only to nephrectomy. The operation of choice in undiagnosed bleeding from the kidney, is polar section, preferably through Broedel's line. Removal of the kidney should not be undertaken, however, before proper function tests have been made.—*The Medical Brief*.

OBSTETRICAL

LATENT ECLAMPSIA.

The expression "eclampsia without convulsions" is justly repudiated, since it is practically equivalent to "convulsions without convulsions." There is of course a well-defined condition which goes by this name and for the designation of which the term latent or marked eclampsia may be justifiable as a metaphor, but which should be entitled to a more positive appellative. In recent years latent eclampsia has come to be recognized as a particular clinical form of gestation toxicosis. It is by no means

clear that conditions so described are always one and the same thing. It is conceivable that the toxemia may be so profound that the convulsive phase is skipped, the patient passing at once into fatal coma. Eclampsia is that form of toxemia of pregnancy which develops at or near the time of labor or in the puerperium, In a large percentage of cases it is the convulsions, or the special factors which bring them about—such as high blood pressure, which constitute the real disease and are the actual cause of death. Yet when no convulsions occur it is claimed that this is due to the very intensity of the toxemia. There is evidently a paradox here, when too many convulsions produce the same results as no convulsions at all. Articles in the *Berliner klinische Wochenschrift*, September 9, by Gottschalk and Freund show that “eclampsia without convulsions” is essentially a postmortem diagnosis. The authors find subjects with all the autopsy signs of eclampsia yet with no history of the latter. There are parenchymatous degenerations in the liver and kidneys, acute hemorrhagic diathesis, and perhaps dubious finds in the placenta. Until the obscurity upon these cases can be effectually cleared up, the diagnosis of “latent eclampsia” may perhaps, as already stated, be justifiable.—*Medical Record*.

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at \$1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

THE GALLOWAY MEMORIAL HOSPITAL.

Ground has been broken for the erection of this long needed hospital, and it promises to be one of the most modern and well equipped institutions of its kind in the South. The officers of the Methodist Church are to be congratulated for starting the campaign for the necessary funds several years ago, and those of all creeds—Jews and Gentiles alike—are to be thanked for their generous financial support.

A hospital, no less than a church, should be looked upon as a house of God, and we hope this institution, when completed, will answer all the purposes for which it is built. While the Methodist Church and Vanderbilt University deserve the credit for starting this movement, we are assured that sectarianism will be put aside and the wards thrown open to people of all creeds. Let us hope that this is true, for otherwise a potentially great institution will become small and insignificant. Let us also hope that the board of directors will be made up of broad-minded men and the hospital staff of medicine and surgery elected from time to time with regard to ability rather than personal friendship. Above all else, let us trust that the twin sisters—politics and graft—may never enter the portals of this building wherein the Almighty will manifest His presence by his wonderful cures. His immortality by the faith of those preparing to join Him in the great beyond.

TO SUBSCRIBERS.

As we are approaching the close of the year and the beginning of a new volume of the *Nashville Journal of Medicine and Surgery* we beg to announce that we shall send statements to all subscribers who are in arrears with their subscription. In this connection we will say that acknowledgments of these statements must be made by those who receive them either with remittances or with explanation as to why payment is not made. Those who receive these statements are legally bound to pay up their arrearages. If they do not, the claims will be placed in the hands of a collecting agency, who will enforce collection by law.

We are reluctant to adopt such a course, but when subscribers absolutely ignore in every way bills for arrearages sent them, they enforce such steps on our part. We are willing to make concessions, if asked for, and we are anxious not to gain the ill will of our readers, but we must have some kind of understanding. Subscription debts differ in no wise from any other obligations and should be liquidated. We beg our readers to let us hear from them without delay. To all who pay up, we hold the premium of a handsome clinical thermometer, which will be sent to each subscriber paying his own subscription.

The break in the walls of the city reservoir recently, permitting the escape of the 50 millions of water in one section of the structure, caused a property loss of nearly a million dollars, and wonderful to relate, not a person was injured. The break, fortunately, occurred at midnight when the adjacent streets were empty. The path of the rushing torrent showed almost incredible devastation.

The Infirmary of Dr. J. T. Wilson, a prominent negro physician, of Nashville, Tenn., was destroyed by fire Sunday morning, November 9, causing a loss of \$25,000. Two patients were rescued from the burning building. The fire was supposed to have been of incendiary origin.

MEDICAL POACHING.

Our brethren of the bar have for long had a custom very closely followed by all reputable lawyers. No counsel will, unless the case is very exceptional, appear in a case where another lawyer has been consulted unless the first has relinquished all claim. Such a custom is also followed among honest doctors. However, where life and health are at stake etiquette must sometimes fall back for the time to humanity and common sense. A recent case was up before the Clerkenwell court in England where this subject was seriously considered. One doctor was called to see his patient whom he attended three days and dismissed as well. Shortly afterwards he was called by the mother who thought the patient was worse. She was reassured by the practitioner, who did not go. Subsequently she called in another doctor, who said the patient had quinsy, and told them to ask the first doctor to relieve it, sending his word that the case was urgent. The first refused to have anything further to do with the case, as another practitioner had been called and did not believe the matter to be urgent. The judge said the first doctor should have accepted the view of the second that the case was urgent, and should have continued his attendance. The second doctor thought it quite sufficient to tell the first that the case was urgent and he should then come and see. Urgency was the point in dispute and the judge decided in favor of the second doctor, though recognizing the usual custom, which practice will show must sometimes be broken. —*E. S. McK.*

BRITISH OPINION OF MEDICAL REQUIREMENTS IN THE U. S.

The London Lancet for September, 1912, has an extensive article, "The British Medical Man Abroad." This discusses the opportunities for and the laws regulating the practice of medicine in the various countries of the world. The Lancet says: The laws regulating the practice of medicine in the various states and territories of the United States differ in a considerable extent in detail. In spirit, however, they are beginning to assume that uni-

formity which all medical reformers must desire for them. The progress of the United States is in no way better shown than in the fact that throughout its vast length and breadth there is now an attempt to secure for the people of the country adequate medical treatment based on scientific grounds. We must continue to warn the British medical man desiring to practice his profession in the United States of America that in all the more enviable centers he will find a vast number, almost a plethora, of medical men, the great proportion of whom have been thoroughly well educated and trained. He must also remember that in the more important states, generally speaking, although the remuneration may rule high, the expense of living is proportionate. Examinations are now required of all applicants in all of the states. This is very different from the way in which the British Medical Press discussed us twenty or thirty years ago.—*E. S. McK.*

FAMOUS TWINS.

It has been stated and reiterated that twins do not become famous. Dr. Kaiser, of Dresden, has made the bold statement that he has known of no famous man who has a twin brother. Dr. Simson, way back in 1862, made a similar statement in the Edinburgh Medical Journal. To contradict this are mentioned Henry and Thomas Vaughan. Those who look up the lives of these two men will not find them very strong citations. Two men named Scott, of Newcastle, England, are also cited as exceptions. They were what is known as "pigeon" twins. Each was born with a twin sister. Pigeon twins are not unusual. One yelked twins are always of the same sex. One of these at least has its development necessarily retarded and the others chances may be greatly prejudiced. There is no embryological or psychological reason why even a true twin, as an embryologist would call it, might not become famous. As for pigeon twins, they are quite independent beings, and it is only during delivery that their lives are in jeopardy. Returning to our mutton, we must reply to the question that twins very rarely attain fame, at least so far as the records teach us. Nevertheless, we must admit that the records of

births up to quite recent times have been very faulty, and a case or two of a twin attaining fame may have escaped the vigilance of the biographers. Let us hear from every one who has anything of value on the subject. Out of the four passably prominent twins mentioned here only one was a doctor. Are there any other twins who attained to such prominence?—*E. S. McK.*

MEDICO-LEGAL COLLECTION.

The Royal College of Surgeons of England, in its museum, has started an interesting Medico-Legal collection. It contains among other things the shaft of a right femur, demonstrating a circular elevation, probably the site of a fracture which was removed from the charred remains of a body taken from the debris after the fire following the terrible siege of anarchists in White Chapel about a year ago. One of the anarchists, Joseph, was known to have a limp, and the indication of a fracture led to the identification. Another specimen of interest is the point of an umbrella four and one-half inches long, which was thrust into the pons of the medulla oblongata from the face and passed through the antrum, sphenoid and brain substance to the depth of one and one half inches. The man died in four days. The umbrella was thrust into him by his opponent in an altercation.—*E. S. McK.*

PUBLIC PROPHYLAXIS AGAINST VENEREAL DISEASE.

Dr. A. Ravogli, in a paper before the Cincinnati Academy of Medicine, October 7, 1912, discussed this subject as only one with his particular wisdom on this particular subject can do. He recommended that all inmates of the houses of tolerance undergo a medical examination at least once a week. The examiner should be skilled in this work, appointed by the board of health and accompanied by an officer. The sanitary condition of the house should be inspected, and but one girl should be allowed to each room. No certificates of health should be given. An inmate found diseased should be taken to the hospital. The presence of an inmate in the house should be *prima facie* evidence that she is not

diseased. If a woman is found in a house who has not been examined she shall be arrested and the house closed. The keeper of a house of tolerance shall report to the police the arrival or departure of inmates, where they came from, name and age.

Rules for clandestine prostitution: Girls frequenting public halls, balls and cafes must be secretly investigated by the police. If found to have no means of support and frequent male visitors, they shall be examined. On complaint of an infected male visitor the girl shall be examined, and if found diseased, sent to the hospital, where they shall be detained till there is no more danger of infection. If they wish to reform they must be treated till safe before they are allowed to go out to work.

In reference to a hospital for venereal patients: The hospital for such patients shall be guarded with secrecy. It must consist of small wards of not more than four to six beds. Means of occupation should be supplied for those able to work. No visitors should be allowed unless upon extraordinary business. He considers the Juvenile Court a most excellent institution to control the question of the prostitution of minors. He thinks that 90 per cent of all cases of venereal diseases come from sexual intercourse. The other 10 per cent are from extra genital or accidental infection. He insisted on the giving up of the idea of the certificate. If the woman was in the house that should be certificate enough that she was healthy. The inspection was not to give a sense of security but to find the foci of infection and remove them to the hospital and control and cure them. The object of reading the paper was to aid in reëstablishing the surveillance of this class of women and preventing the spread of venereal diseases.—*E. S. McK.*

THE SCIENTIFIC STUDY OF THE ALCOHOLIC PROBLEMS.

In New York City in 1870 a number of physicians and medical experts formed an organization called the American Society for the Study of Alcohol and Other Narcotics. This was the first medical association in the world to take up the study of alcohol and inebriety, and determine from clinical experience, laboratory

studies, and grouping of facts, the phenomena of the spirit and drug neuroses.

The special purposes was to study this subject, above all theories and conclusions, particularly its etiological, physiological, therapeutic and medico-legal relations; also to compile and make available each studies for home, office and institutional treatment, and point out the remedies and prophylactic measures for restoration and cure.

The forty-second annual meeting of this society will be held at Washington, D. C., December 11, 1912. A large program of scientific papers from medical men, many of them distinguished foreigners, will be presented. This meeting and the subjects discussed will attract a great deal of attention, not only among medical men, but an increasing number of laymen, who have an intense personal interest in alcohol and drug taking.

Programs and further information can be had by addressing the Secretary,

DR. T. D. CROTHERS,
Hartford, Conn.

SCIENTIFIC LESSON FROM THE ATTEMPTED ASSASSINATION OF COLONEL ROOSEVELT.

Arthur MacDonald, a criminal anthropologist, of Washington, and author of a Senate document entitled, "Man and Abnormal Man," suggests a plan to lessen or prevent crime and other abnormalities, especially such as the attempted assassination of Colonel Roosevelt.

Mr. MacDonald has been advocating in Congress, State Legislatures, and with mayors of large cities, this plan for many years. It is to establish laboratories or bureaus for the scientific investigation of criminals and other dangerous abnormals. He believes that every large city, and every State, and especially the Federal Government, should have such a laboratory.

When anyone sends to the President, the Governor, or Mayor, or any prominent citizen threatening letters, or repeatedly utters threatening words, or attempts to injure such officials, or is unreasonably insistent in de-

manding to see them *personally*, such individual should be detained at least a few hours and thoroughly studied by scientific experts in criminal anthropology, psychophysics and social pathology.

A bill for such a laboratory is now pending before the Judiciary Committees of both Houses of Congress. The members of these committees are as follows:

Committee on Judiciary of the Senate—Senators Clark, of Wyoming, Chairman; Nelson, Minnesota; Dillingham, Vermont; Sutherland, Utah; Brandegee, Connecticut; Borah, Idaho; Brown, Nebraska; Cummings, Iowa; Root, New York; Bacon, Georgia; Culbertson, Texas; Overman, North Carolina; Rayner, Maryland; Paynter, Kentucky; Chilton, West Virginia, and O'Gorman, New York.

Committee on Judiciary of the House—Representatives Clayton, of Alabama, Chairman; Henry, Texas; Webb, North Carolina; Carlin, Virginia; Rucker, Missouri; Floyd, Arkansas; Thomas, Jr., Kentucky; Graham, Illinois; Dupre, Louisiana; Littleton, New York; McCoy, New Jersey; Davis, West Virginia; McGillicuddy, Maine; Sterling, Illinois; Moon, Pennsylvania; Higgins, Connecticut; Howland, Ohio; Nye, Minnesota; Norris, Nebraska, and Dodds, Michigan.

By a patient study of these dangerous, unbalanced and often illusioned persons, who may be called mattoids, their eccentricities and peculiar behavior under different conditions of life can be determined to such an extent that we shall be able to detect them in advance. At present it is almost impossible to do this, because of the little or no knowledge concerning them. This state of our ignorance is due to the want of systematic scientific and sociologic investigation.

Millions of dollars are annually expended by our Government for the scientific investigation of the antecedents, peculiarities and behavior of some little bacillus, causing the death of plants or animals, but little or nothing is given for a similar study of the larger human bacillus, which has caused this country to suffer losses beyond human calculation.

Who can estimate the mental, moral and financial cost of the United States of the assassination of Garfield, and McKinley? Shall we wait till more of our Presidents, Governors, Mayors, or other distinguished citizens lose their lives at the hands of these mattoid assassins, before we begin a serious, scientific and systematic study of such dangerous individuals?

MEDICO-LEGAL SOCIETY.

The Medico-Legal Society announces its opening fall meeting at the Waldorf-Astoria on Wednesday, October 23, 1912, at 8 o'clock p.m., for the discussion of "*Medical Expert Testimony in Homicidal Cases Where Insanity is Pleaded*," and the merits of the Bill proposed by ex-Chief Justice Emery known as the Maine Bill.

1. Paper by Clark Bell, entitled "Medical Expert Testimony," and the merits of the Maine Bill.

2. Replies by ex-Chief Justices. Hon. Simeon E. Baldwin, of Connecticut; Hon. Orrin N. Carter, of Illinois; Hon. Charles M. Start, of Minnesota; Hon. Charles E. Frick, of Utah; Hon. William T. Spear, of Ohio; Hon. John W. Rowell, of Vermont; Hon. Eugene B. Gary, of South Carolina, and other Chief Justices of the Supreme Courts.

3. Views of Dr. R. L. Parsons, of New York; Clarence A. Lightner, Esq., of Detroit, Mich.; Charles E. George, Esq., of San Francisco; Dr. E. S. McKee, of Cincinnati, Ohio, and other prominent alienists and medico-legal jurists.

4. The American Institute of Criminal Law and Criminology; the National State and City Bar Associations; the State Medical Societies, and all cognate associations are invited to send delegates to the discussion, and their members to contribute to the discussion, and the literature will be sent on application.

5. Historical Sketch of the Supreme Court of Oregon. By Judge J. C. Moreland, of Salem, Oregon. The Supreme Court of West Virginia. By William B. Matthews, of Charleston, West Virginia.

6. The Chief Justices of the Supreme Courts of the States. By the Editor. Both professions are invited. A general attendance is desired.

CLARK BELL,
Secretary.

T. D. CROTHERS,--
President.

MINE SURGEON (MALE.)
Bureau of Mines. November 20, 1912.

The United States Civil Service Commission announces an open competitive examination, for men only, for mine surgeon, on November 20, 1912, at the places mentioned in the list printed hereon. From the register of eligibles resulting from this examination certification will be made to fill a vacancy in this position in the Bureau of Mines at a salary ranging from \$2,000 to \$3,000 per annum, and vacancies as they may occur requiring similar qualifications, unless it is found to be in the interest of the service to fill any vacancy by reinstatement, transfer, or promotion.

The person appointed to this position will be expected to give instruction to the first-aid miners of the Bureau of Mines, visit them at safety cars and stations, and make sure by supervision, direction, inspection, and report that they are capable of performing their duties as instructors in first aid to miners. He will superintend the carrying out of sanitary methods in connection with cars, stations, apparatus, and the personal habits of those in mines and villages; will write miners' circulars on instruction, etc., visit mines, and observe and report on sanitary conditions in general and assist in bringing about improved sanitary conditions underground. Pathological studies will also be made as to the effect upon the human system of poisonous gases and death by shock at mine disasters. In addition he must be sufficiently active and familiar with mining to put on artificial breathing apparatus and, with the rescue force, to enter mines immediately after fires and explosions in order to take blood samples and record conditions before removal of remains from the poisonous atmosphere.

Competitors will be examined in the following subjects, which will have the relative weights indicated:

<i>Subjects</i>	<i>Weights</i>
1. Letter writing (the subject matter to be upon an assigned topic of medical or surgical interest)-----	5
2. Anatomy and physiology (regional and minute anatomy, general physiology, the physiologic functions and relations of organs)-----	10
3. Surgery and surgical pathology (general and special surgery, surgical diagnosis, pathology, treatment, and technic -----	20
4. Chemistry, materia medica, and therapeutics (elementary questions in inorganic and organic chemistry, the physiologic action and therapeutic uses and doses of drugs_	10
5. Bacteriology and hygiene (the technic of bacteriologic laboratory methods and the practical application of the principles of bacteriology and hygiene to prophylaxis and treatment) -----	15
6. General pathology and theory and practice of medicine (the etiology, pathology, symptomatology, and treatment of diseases)-----	20
7. Training, experience, and fitness-----	80
Total-----	100

Applicants must be graduates of a reputable medical college and must show not less than three years' postgraduate experience in medical and surgical practice about coal mines, including mine accidents, occupational diseases of minesers, etc. Special credit will be given for experience in the rendering of first aid to the injured in mine accidents; definite statement should be made as to the amount and extent of all experience claimed.

Statements as to training, experience, and fitness are accepted subject to verification.

Applicants must not have reached their fortieth birthday on the date of the examination.

This examination is open to all male citizens of the United States who meet the requirements.

Persons who meet the requirements and desire this examination should at once apply either to the United States Civil Service Commission, Washington, D. C., or to the secretary of the board of examiners at any place mentioned in the list printed hereon, for Form 1312. No application will be accepted unless properly executed and filed with the Commission at Washington. In applying for this examination the exact title, as given at the head of this announcement should be used.

As examination papers are shipped direct from the Commission to the places of examination, it is necessary that applications be received in ample time to arrange for the examination desired at the place indicated by the applicant. The Commission will therefore arrange to examine any applicant whose application is received in time to permit the shipment of the necessary papers.

Issued October 21, 1912.

Obituary

DR. L. B. GRADDY.

We are grieved to announce the death of Dr. L. B. Graddy, who died at the age of 57 years at the home of his wife's relatives in Lexington, Tenn., November 10, 1912. Dr. Graddy was an alumnus of the medical department of the University of Nashville and was for many years Professor of Diseases of the Eye and Ear in that institution. On the dissolution of the medical college with which he had for so many years been identified, he moved to Texas, where, after six months, his health failed, and he came back to Lexington, Tenn., where he died. Dr. Graddy was a skillful and successful master of his specialty and was widely known throughout the South and Middle West. His death is a great loss to the profession and is a source of great grief to his friends and patrons.

Reviews and Book Notices

The Surgical Clinics of John B. Murphy, M.D.—The Surgical Clinics of John B. Murphy, M.D., at Mercer Hospital, Chicago. Vol. I, No. 5. October. Octavo of 155 pages. Illustrated. Philadelphia and London. W. B. Saunders Co., 1912. Published Bi-Monthly. Price per year, paper, \$8.00; Cloth, \$12.00.

We acknowledge with thanks to the enterprising publishers the receipt of the October number of the Surgical Clinics of John B. Murphy, M.D. This number presents clinical lectures covering almost the entire field of surgery, and possesses equal interests with foregoing numbers of the series. The work done at that celebrated clinic, the methods pursued and the wonderful results obtained by the celebrated surgeon, render the presentation of these clinics in serial form of incalculable value to the practitioner who is unable to attend them *in propria persona*. In this number Dr. Murphy opens the series with a valuable lecture on Anæsthesia. Lectures follow on Nephrolithasis Cholecystitis, Gastro-Duodenal Ulcer, Appendiceal Abscess, Exophthalmic Goitre, Tumor of Spinal Cord, Retroversion of the Uterus, Ununited Fracture, Ankylosis of Left Elbow, etc. The descriptions of the operations and the comments of the lecturer are clear and to the point so that the reader clearly understands them, an art that no teacher possesses in as great degree as Dr. Murphy.

Diseases of Children.—A Practical Treatise on Diagnosis and Treatment for the Use of Students and Practitioners. By Benjamin Knox Rachford, Professor of Diseases of Children, Ohio-Miami Medical College; Department of Medicine of University of Cincinnati; Pediatrician to the Cincinnati Hospital; Good Samaritan Hospital and Jewish Hospital; Ex-President of the American Pediatric Society, and Member of the Association of American Physicians. New York and London. D. Appleton & Co. 1912.

This excellent work will meet with a hearty reception from the profession, as recent works upon pediatrics are rather rare. The author has executed a well arranged and comprehensive treatise, especially framed for the diagnosis and treatment of diseases of

children. He dwells, and very properly, on the fact that the diseases of infancy and childhood differ in their clinical manifestations from corresponding diseases in the adult, for physiological rather than pathological reasons. The author has in this work dwelt upon the physiological factors of diseases in infancy and childhood and has made practical application of these facts in the prophylaxis and treatment of these diseases. Everything has been omitted in the way of etiological discussion and pathological findings with a view to reducing the work to a thoroughly practical and working basis. We are sure our readers who desire to keep in the van of progress will find in this work a useful and thorough guide.

A Treatise On Pellagra for the General Practitioner.—By Edward Jenner Wood, S.B., M.D. Chairman of the Pellegra Commission, North Carolina Board of Health; Member of the American of Tropical Medicine; Fellow of the London Society of Tropical Medicine and Hygiene; Formerly President of the Medical Society of North Carolina, etc. With Thirty-eight Illustrations in Text. New York and London. D. Appleton & Co. 1912.

This excellent text-book and guide for the general practitioner should appeal to the profession of this part of the United States, as it has been carefully prepared by a Southern physician for the instruction of Southern physicians upon a disease essentially tropical in its habitat. The interest in this disease, which has only recently manifested itself as a scourge in the Southern states, is widespread and any work that tends to aid in the recognition of the disease and outline the management of cases when recognized should receive a hearty welcome and patronage. This book does that and presents, in well arranged form, a thorough exposition of the subject. We commend the work to the profession as a most reliable guide and handbook.

Sex Hygiene for the Male, and What to Say to the Boy.—By G. Frank Lydston, M.D., Chicago. Riverton Press.

This great criminologist and urologist is too well known to be told about. Suffice it to say that his book is up to the high stand-

ard one would expect from the author. The book is written for parents, teachers and physicians in the fight for our boys, and should be widely read.—E. S. McK.

The Soul and Sex in Education.—By J. D. Buck, M.D. Stewart & Kidd Co., Cincinnati.

The author has been a practitioner and teacher of medicine in Cincinnati for 50 years, besides a deep student, thinker and author. In this book the author deals learnedly of love, marriage, celibacy, scientific psychology, inspiration and revelation and other questions. A good book for teachers and parents. Helpful to both adult and child.—E. S. McK.

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NASHVILLE JOURNAL — OF — MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

VOL. CVI.

DECEMBER, 1912.

No. 12.

Original Communications

MEDICO-LEGAL NOTES.

By E. S. McKEE, M.D., Cincinnati, Ohio.

A COMMISSION OF EXPERT WITNESSES.

Five physicians of Minneapolis, all specialists in their respective lines, have been placed at the disposal of the judges of that court by the Hennepin County Medical Society. The commission will be consulted whenever a question comes up in which the mental condition of the prisoner is a prime factor. Dr. C. H. Bradley, president of said society, is of the opinion that the work will be a long step in advance in the interest of justice. The step is surely along modern lines and will enable the judges to get at the bottom of each case. It would seem that justice would be meted out to the prisoner under such a fair system.

CAN'T PAY FOR ACQUIRING KNOWLEDGE.

That other twin, St. Paul, voted its health officer \$200.00 for expenses to attend the International Congress of Hygiene at Washington. Corporation Attorney O'Neill gave the opinion that this was an illegal expenditure of money. "The common council," he said, "is authorized to provide under the charter from the general fund for current and incidental expenses of the city. The Supreme Court has ruled that this means usual and reasonable necessary expenses not otherwise provided for. Attending

the congress in question is not carrying into effect any of the powers of discharging any of the duties given and imposed by the charter of the health commissioner." St. Paul is practicing expensive economy.

- OPTOMETRY IN KENTUCKY.. -

M. C. Carey, an optician of Whitely County, was denied a writ of prohibition to prevent Judge Sampson of Whitely Circuit Court fining him for practicing medicine without a license. Carey was testing eyes and ordering lenses, which he has ground by a firm in Cincinnati. He was indicted, plead not guilty and waived a jury. Judge Sampson said he would impose a fine. Carey petitioned for a writ of prohibition, alleging that the fine would be below the amount for which he could appeal, and he would have no relief. He denied practicing medicine or treating eyes, and declared that his business would be injured. The Appellate Court ruled that as there was no charge that Judge Sampson was about to perform an act beyond his jurisdiction, the writ could not be granted.

THE RICH AND THE POOR.

The New York Times takes up again that old question of doctors charging the rich more than the poor. It cites the recent testimony of a Pittsburg physician, who testified in court in behalf of a rather large bill for a brother practitioner who unsuccessfully treated a millionaire. He stated that doctors adjust their charges according to the fortunes of their clients "every time." This is, of course, to the most of us no news, as it has been confessed, condoned, confirmed many times. Still it causes a minute shock to the rich, if not to the poor, every time the subject is brought up. The rich can not quite see the righteousness of different prices for different persons for the same services. The editor of the Times condemns the physicians for Robin Hood like robbing the rich and giving it to the poor. If the matter is looked into it will be found that the rich pay much less in proportion to their incomes than the poor. The trouble is that we go at the

matter wrong end first. We should have a good stiff price for the rich—our regular rates—and make a reduction for the poor who are manifestly unable to pay such charges. No one could blame us for making a reduction for a poor patient, while they can and do blame us for increasing our charges for the rich—at least the rich do.

THE DIVORCE OF THE INSANE.

Thrice unfortunate he or she who is married to the incurably insane. Religious or other grounds may fix ones views on this subject, but can not lessen the great misfortune. The French have been giving this subject special attention. The subject was carefully considered in the 1910 meeting of the Congress of French Alienists and Neurologists, and this consideration resulted in the introduction of bills into the Chamber of Deputies. Dr. Lucien Graux, director of the *Gazette Medicale de Paris*, has collected much information on the subject in a little booklet, *Le Divorce des Alienes*.—Graux instituted an extensive correspondence in his journal, which included lawyers, doctors, legislators and others who would be interested and posted on the subject. Dr. Graux sums up and critically discusses the subject and the evidence presented. His own sentiments lean towards a legal release from those individuals in this unhappy state who desire it.

PRACTICING A PROFESSION OBLIGATES ONE TO ACQUIRE THE REQUIRED KNOWLEDGE.

The High Court of Leipsic, the highest judicial tribunal in Germany, has rendered an important decision on this point. It is important, because the courts in trying unqualified persons charged with negligent or unskillful treatment of patients, have too often been inclined to regard it as an extenuating circumstance that an unqualified person could not certainly know that his treatment might eventually prove injurious. The Court also declared itself of the principle that whoever undertook to exercise a profession was under an obligation to acquire the necessary knowledge. The defendant had treated, nonsurgically, a case of cellulitis of the

thigh for which a qualified medical man had recommended an operation. The result was that after some time disarticulation of the femur became necessary. The lower Court found the defendant guilty of causing bodily injury by neglect. The case was appealed and the decision maintained by the higher Court. The judge, while admitting that the results might not have been better had the operation been performed, the charge of neglect was maintained on the ground that the defendant, knowing that he had not sufficient medical training, had undertaken to treat a case which a qualified medical man had characterized as very severe and needing immediate operation.

SPECIALIZING ON SPECIALISTS.

The Appeal Court of Honor of the Kingdom of Saxony has recently rendered a decision which is fraught with interest to specialists. The Court decided that a man shall not be allowed to call himself a "specialist for internal and external tuberculosis". The Court, on rendering judgment, said that in accordance with such leading medical men as Czerney, His, Quicke and others, a division of the medical practice into too many branches ought to be avoided. A specialist might devote himself to the diseases of certain regions or organs of the body, such as the nervous system, the eye or ear, but could not claim as his specialty a disease which might invade any region or organ of the body. The defendant was not fined, as he had acted in good faith, but was asked to remove the objectionable words from his door, visiting cards, etc. The Court further decided that the term, "Specialist for Massage of the Nerves" was not in accordance with medical ethics, because massage of the nerves was too limited a branch of treatment to be regarded as a specialty, also because it was doubtful whether the method was a scientific procedure. This practitioner was not fined, but as in the preceding case, was ordered to abstain from using the words quoted.

Proceedings of Societies

THE ACADEMY OF MEDICINE, CINCINNATI.

Monday, November 4, 1912.

SECTION ON SPECIALTIES.

Paper—"Lenticular Fluorescence with Reference in Particular to the Eye of the Observer."—Dr. Jesse Wyler.

Paper—"Borderline Cases of Pityriasis Rosea and Tinea Circinata (Ringworm of the Body)."—Dr. Moses Scholtz.

NOTES.

Announcement.—The Ohio Valley Historical Society will meet at Miami University, Oxford, Ohio, November 7, 8 and 9. General subject, "Education in the Ohio Valley Prior to 1840."

An excellent oil painting of Daniel Drake is on exhibition at the Cincinnati Public Library. All physicians are welcome and should take advantage of this opportunity. November 6, 1912, is the sixtieth anniversary of the death of Daniel Drake.

A copy of the Constitution and By-laws of the Academy of Medicine was inclosed in the corner stone of the Union Central Life Insurance Company Building.

In the absence of the president and both vice presidents, on motion of Dr. Drury, Dr. Joseph Ransohoff was elected temporary chairman.

Dr. D. T. Vail presented a patient with tattooing of the cornea for cosmetic effect. Dr. James H. Williams said that in most cases of tattooing the immediate result was good, but that absorption takes place in a year or two and necessitates repeating the operation. He hoped the case would be presented again in a year or two.

Dr. Percy Shields presented a specimen of dermoid cyst re-

moved by operation. Cyst contained a large quantity of oily substance, much hair, some bony structure and teeth.

Dr. Jos. A. Hall reported a case of abdominal pregnancy and presented specimen. Placenta was attached principally to the cul-de-sac and posterior part of the pelvic wall. Gestation about four months. Partial rupture had occurred.

Dr. J. Ambrose Johnston presented a specimen and case report of an ovarian fibroma (true), weight three and one-half pounds. Patient also had gallstones. The gall-bladder was in hour-glass contraction, with a stone size of walnut in fundus and a number of smaller stones below the stricture. Both operations were done and appendix removed at one sitting. Good recovery.

Dr. A. E. Osmond read a paper on "Blood Count and Blood Examination." The paper was of immense practical value and presented many practical points gained by several years' work in the Cincinnati Hospital Laboratory. Dr. Osmond presented a chart for tabulating the findings in blood counts which prevents errors. Special mention was made of conditions and diseases where a blood count was of special diagnostic value.

Dr. R. D. Maddox presented a little apparatus for filling the pipette in making blood counts devised by himself, which is very accurate, and obviates the necessity of using the mouth as by older methods. It is very simple and ingenious and possesses great merit.

Dr. A. L. Knight, in discussion, complimented the work of Dr. Osmond, and dilated on the possibilities of error. He spoke of the possible variations in the blood of a patient at different times, even in as short intervals as one or two hours, particularly in malaria.

Dr. Moses Scholtz presented a patient and discussed the points of differential diagnosis in a case of erythema multiforme of a large papular type.

Dr. D. D. McNeen reported a case of Cæsarean section on a primipara. The indication for operation was a mass in the cul-de-sac, making delivery with forceps impossible. Operation done in patient's home. Incision into the uterus was made over the placenta, and great hemorrhage occurred. Entrance was forced

through the placenta and delivery accomplished. Child resuscitated, but only lived a short while. Mother's recovery uneventful except for fat necrosis in the abdominal wall. Dr. DeNeen also presented a specimen of osteo-sarcoma of hyoid bone removed from an animal.

Dr. Dudley Palmer reported a case of duodenal ulcer perforation simulating appendicitis; operation; recovery. He also reported a case of pylorotomy for ulcer area with evidence of beginning malignancy with presentation of the specimen. Dr. W. D. Haines, in discussion, said that nearly all cases of duodenal perforation sent into the hospital had symptoms of appendicitis, and were frequently so diagnosed. This is due to direction of escape of duodenal contents into right iliac fossa.

Dr. C. T. Souther presented a specimen of cystic tumor at base of tongue removed by operation. Case seen and operated on by Dr. W. C. Harris and Dr. Souther. Tumor contained mucus and was somewhat pedunculated. Pedicle was attached between circumvallate papillæ and the epiglottis.

Monday, November 11, 1912.

Paper.—“Pituitrin: A New Therapeutic Agent in Obstetrics.”—

Dr. G. Mombach.

Paper.—“The Diagnosis of Important Pathological Changes Associated with Inflammation of the Vermiform Appendix and Indications for Treatment.”—Dr. Walter R. Griess.

Paper.—“Retrocecal, with Report of a Case.”—Dr. J. Louis Ranshoff.

NOTES.

Dr. Oscar Behrhan was elected to membership.

Dr. J. A. Thompson addressed the Academy as a member of the Committee on Public Policy and Legislation of the Ohio State Medical Association. He stated that Longworth and Renner seemed unwilling to commit themselves as to their attitude towards the Owen Bill, or how they would vote in reference to any change being made in the law on that subject. Letters to

Bowdle and Allen were very courteously answered in the affirmative and the profession can depend on their support. Judge Wanmaker has already put himself on record as in favor of the medical practice act as it now stands.

The secretary read a communication from the Cincinnati Medical Book Company offering the use of its reading rooms for the use of committees of the Academy at any time. On motion of Dr. Drury, seconded and carried. The secretary was instructed to thank Mr. Benton for the courtesy extended.

Dr. H. K. Stoll presented a number of very interesting specimens of pathological conditions of the eye well mounted.

Dr. W. D. Haines presented a specimen of goitre, very large fresh specimen removed on same day, weight about three pounds. Operation done to relieve mechanical condition present. Patient had gone through all the symptoms of hyperthyroidism except exophthalmus.

The paper on "Lenticular Fluorescence with Reference in Particular to the Eye of the Observer," was read by Dr. Jesse Wyler. Dr. Wyler then demonstrated the effect to a large number of members with his apparatus especially designed to show the effect of light rays on the lens when the light was passed through certain colored glass media. The therapeutic effect of euphos glass was shown.

Dr. Moses Scholtz read his paper on "Borderline Cases of Pityriasis Rosea and Tinea Circinata." The paper contains reports and photographs of personal cases and takes up the differential diagnosis very carefully.

In discussion, Dr. M. L. Heidingsfeld made a plea for a more simple nomenclature and a possible division of the cases into parasitic and non-parasitic. He said that it was not always easy to demonstrate the parasitic nature in the more mild forms, and contamination was apt to occur. He held that cases occurred mostly in spring and fall, and that new underwear was a frequent source of infection. New underwear should be laundered before being put next to the body.

Monday, November 18, 1912.

Paper.—“The Value of Artificial Pneumothorax in Selected Cases of Pulmonary Tuberculosis.”—Dr. Louis V. Hamman, Associate Professor of Medicine, John Hopkins Medical School.

NOTES.

The last meeting was well attended. With Dr. Louis V. Hamman, John Hopkins, as essayist for the next session a large meeting is assured. Dr. Hamman has developed this technique and will demonstrate it at a clinical lecture held Tuesday morning at the Branch Hospital.

President Porter announced the receipt of a telegram from Dr. Pirrung in New York, stating that Mr. W. Arbuthnot Lane will address the Academy on the evening of November 25.

Dr. Albert H. Freiberg presented a case of structural scoliosis, overcorrected according to principles laid down by Abbott, of Portland, Me. The plaster-paris jacket had been put on with the aid of special apparatus devised by Abbott. Dr. Freiberg believes these cases are due to malnutrition resulting in imbalance of musculature of trunk. The patient will be kept in overcorrected position for about five months, with every effort used to bring nutrition to par. The patient will then be shown to the Academy again.

Dr. S. J. Goldberg presented a case of congenital deformity of chest in a young man otherwise of splendid physique. The deformity consisted of decided sinking in of the xiphoid appendix. There was practically no visceral displacement.

Treasurer A. G. Drury announced that many members were still in arrears for the last year, and urged prompt settlement of these accounts to facilitate the business of the Academy.

Dr. G. Mombach's paper on “Pituitrin: A New Therapeutic Agent in Obstetrics,” proved decidedly interesting. Pituitrin is decidedly valuable in hydramnios and in conditions where the induction of normal uterine contractions are desirable. It is claimed that tetanus uteri is never produced. The use of this drug obviates in a large measure the application of forceps and other sur-

gical procedures. It is, of course, imperative to rule out the various mechanical dystocias. Dr. Mombach reported the favorable use of pituitrin in four cases.

Dr. Wm. Gillespie, in discussion, doubted its great utility, holding that correction of malpositions and malpresentations was the crux of the situation in prolonged labor.

Dr. Walter Griess read an excellent paper on "The Diagnosis of Important Pathological Changes Associated with Inflammation of the Vermiform Appendix and Indications for Treatment." He held that pain and temperature were the cardinal symptoms, and that perforation was generally insidious in onset and symptoms. Early operation is desirable, and under favorable conditions the mortality would be reduced to 0.5 per cent. Dr. Griess objects to the use of the ice-bag in any stage of the disease, particularly after the first forty-eight hours; prefers heat. If patient will not consent to operation, avoid catharsis and high rectal enemata.

Dr. Joseph Ransohoff held that it is difficult to diagnosticate intra-abdominal conditions prior to operation. Is particularly impressed with the blood count in these cases; four-hourly counts should be made. Decided leucocytosis usually indicates pus formation. He held that chronic conditions are more difficult to prognosticate than acute.

Dr. J. E. Caldwell believes delay to be dangerous in appendicitis. He cited several cases with apparently favorable symptoms coming to operation, with most deplorable conditions divulged.

Dr. Tate finds diagnosis at times difficult, especially when called in late in the case. The symptoms of obstruction and gangrene are at times masked.

Dr. Griess, in closing, plead for greater skill in diagnosis in these cases, holding that with care the morbidity and mortality tables could be markedly affected favorably.

Dr. J. Louis Ransohoff read a case report of a recto-cecal hernia, illustrated by an excellent drawing and several X-ray plates. Dr. Sidney Lange demonstrated the method of obtaining these pictures.

Monday, November 25, 1912.

Address.—“Medical and Social Progress.”—Dr. William Anderson, Newport, Ky.

Followed by a Lunch and Smoker.

NOTES.

The Bulletin takes this opportunity to announce that the First Councilor District Meeting will have the following program for Monday, November 25. The meeting is to be held at the Cincinnati Hospital amphitheatre:

11 a.m.—Operative Clinic. Mr. W. Arbuthnot Lane, London.

3 p.m.—Address. Dr. Mark Milikin, Hamilton, Ohio, President District Society.

Address.—Mr. W. Arbuthnot Lane, London.

Address.—Dr. J. C. M. Floyd, Steubenville, Ohio; President Ohio State Medical Society.

Clinic.—Dr. Fred Forchheimer, Cincinnati.

Mr. W. A. Lane is one of the most distinguished surgeons in the world, and Cincinnati should feel especially honored to have him here. His clinic in New York at the Congress was the largest in point of attendance during the congress. He had three overflow operation rooms going, and even then the crowd could not be accommodated. About 2,000 surgeons tried to see the work. The district meeting should be the largest yet held in Cincinnati.

Application for membership was received from Dr. W. A. Gardner and Dr. Thomas M. Stewart.

Dr. H. K. Dunham announced that Dr. Hamman would hold a clinic at the Branch Hospital on Tuesday morning, November 19, 1912.

Dr. J. E. Pirrung moved that the Academy of Medicine entertain the First Councilor District Meeting with a lunch and smoker on Monday evening, November 25, 1912. Seconded and carried.

The president, Dr. Porter, then introduced the speaker of the evening, Dr. Louis V. Hamman, of John Hopkins University.

Dr. Hamman read a paper and gave a demonstration of apparatus used. The title of the paper was “The Value of Artificial

Pneumothorax in Selected Cases of Pulmonary Tuberculosis." Dr. Hamman took up the history of this procedure, spoke of two special methods, of the work of Murphy and others, and advised the use of artificial pneumothorax in certain selected cases of pulmonary tuberculosis, especially where one lung was distinctly more seriously affected than the other. The incidental dangers were carefully considered, as well as means for their prevention. The general conclusion was that this procedure gave results sufficiently out of the ordinary to justify its use in selected cases, and that this is proven by about five hundred cases in the literature.

A rather free *pro* and *con* discussion followed. Dr. B. F. Lyle said the possible dangers were sufficiently great to make us very cautious in the use of this procedure. Dr. E. W. Mitchell expressed his appreciation of Dr. Hamman's excellent paper and said that the work along this line was gradually assuming a definite place in the therapy of tuberculosis. Dr. S. P. Kramer thought the rationale rather paradoxical in that it rested one lung with a compensatory effort or overwork of the other; that if fresh air was good why should shutting this air out of one lung be beneficial; the loss of lung space in this method frequently became a permanent thing. Dr. Iglauer asked if air or nitrogen gas had been used in the fatal cases reported, and if they had been X-rayed before and after treatment.

Dr. Dunham said that the paper proved Dr. Hamman's superior ability and good judgment in selecting his cases, and that everything depended on selecting the case or recognizing the special indications for treatment. The clinical results after all are our guide, and that Dr. Hamman had proved that the benefit was greater with artificial pneumothorax than any other therapy where it was indicated. Dr. Faller took very much the same ground as Dr. Kramer, and could not see on theoretical grounds at least why the treatment should be markedly beneficial, as it was contrary in some of its principles to the recognized methods. Dr. Lange said in his experience advanced tuberculosis was never unilateral, at least according to X-ray findings.

Dr. P. G. Woolley held that while the deductions of Dr. Kramer were logical, there was a possible benefit to the circulation of

the affected side, and the absorption of antibodies was perhaps greatest where tension was relieved. Dr. C. T. Souther asked as to the relative therapeutic value of artificial hydrothorax compared to that of artificial pneumothorax, and where effusion was present and aspirated if the introduction of salt solution in place of air would give as good results.

Dr. Hamman closed the discussion by answering all of the points raised.

Monday, December 2, 1912.

REPORT OF THE MILK COMMISSION.

"Brief Case Reports Illustrating Ocular Symptoms in Acute Nephritis, Lesions of the Hypophysis, and Pernicious Anemia."

Dr. Robert Sattler.

Paper.—"Mercury vs. Salvarsan in the Treatment of Syphilis."—

Dr. Edwin Shields.

NOTES.

The meeting of November 25, 1912, was turned over to the First Councilor District Meeting. Meeting called to order by Dr. Robert Carothers, who asked Dr. Herschel Fisher, Lebanon, O., President-elect of the Councillor District, to take the chair. Dr. Fisher then presided. There was a very large attendance.

The special order of business was a paper by Dr. W. W. Anderson, Newport, Ky., "Medicine and Social Progress." The paper was most excellent, scientific, and contained a great deal of good, sound reasoning and philosophy. It represented a great deal of thought and study, and contained much in a statistical way that is not easy to obtain. He took up the State care of the insane and made many comparisons between the relative treatment of the insane and criminal. He dealt at length with the problem of the propagation of the criminal and insane, with the laws that do, and those that should, govern matrimony. The paper created much comment and provoked a discussion of which any essayist should be proud.

The discussion was opened by Dr. David I. Wolfstein, who took the ground that if we expected to gain any headway we must forever separate the problems from politics and put it on a business and expert basis, and add to this what we know to be absolutely scientific facts, and let the public have the benefit, and not the politician.

Dr. Dan Millikin then spoke in his own inimitable way of the relation of the doctor to social progress, and gave an inspiring talk which made everyone feel glad for once that he belonged to the profession of medicine.

Dr. John M. Withrow complimented the essayist on the paper, and discussed the feature that had to do with the value of these teachings to the children and the next generation.

Dr. John H. Landis brought out some of the etiological factors that are responsible for present social and economical conditions. He showed how easy it was to place the blame in the wrong place. He discussed the problem of poor tenement quarters and their relation to disease, heredity, crime and immorality.

Dr. Anderson closed the discussion.

The meeting adjourned to the social session, consisting in a lunch and smoker to the district meeting by the Academy.

Dr. M. Salzer was surprised to find a bunch of keys in his overcoat pocket last Monday evening at the Academy. Owner will please call on Dr. Salzer and obtain reward.

Selected Articles

A FEW DIAGNOSTIC POINTS IN GENITO-URINARY DISEASES.*

BY DRs. M. M. SWORDS AND HENRY F. ADER.

In presenting this paper for your consideration, the topic of which deals with a few diagnostic and general suggestions of genito-urinary diseases, we wish to state that we have nothing new to offer on the subject; but will endeavor to enumerate some facts and suggestions which we sincerely hope will be of interest and value to the general practitioner of medicine. It is not our intention to delve too deeply into the conditions and diseases of the genito-urinary tract, but only to offer a few remarks on each of what we consider the primary essentials that should be known and recognized, giving you as briefly as possible our experience in this very broad and scientific field of medicine, without rehashing or attempting to burden you with details of a subject about which much has been written, copied and rewritten.

Among the first considerations in the primary examination of your patient is intelligent, painstaking interrogation. This not only assists you in gaining the history of the onset, symptoms and conditions of an existing malady, but is the greatest asset at your command in obtaining, first of all, the confidence of your patient. That confidence is of paramount importance, and can not be too highly estimated; especially is this true in as far as the genito-urinary clinician is interested. For, remember, your patient may have come to take up his abode with you for quite some time. (This is especially true of gonorrheics, and it will require all the skill, patience and tact at your command to have him remain cured or be otherwise discharged.) History also affords you the

*Read before the Orleans Parish Medical Society, August 12, 1912.

opportunity to judge the diseases to which your patient is most liable; habits and environments likewise. The family history should be noted as to tuberculosis, malignancy, rheumatism and gouty affections, as they are the diseases in which hereditary predisposition plays such an important role, and will oftentimes be of good reasons for suspecting certain diseases of which these maladies formed a formidable background. Information about maladies of which near relatives have died is of value, often denoting hereditary characteristics.

Special Interrogation.—Relating of symptoms in detail by intelligent, observing patients is often of value, for, in certain conditions, apparent unimportant symptoms to the casual observer would, on the other hand, to the specialist, prove pathognomonic of a specific disease. Detailing of symptoms is not always reliable, consequently can not be depended upon, and must be corroborated by other findings.

The cardinal points for consideration are: the urine, frequency and urgency (whether night, day, or both), the changes in the stream, presence or absence of pain preceding, during or after urination; admixture of blood with the urine, whether constant, primary, or terminal in character; the effect of rest and exercise regarding hematuria; cloudy urine, pus and other substances. These forming the basis of this paper, we shall now proceed to consider each of these conditions separately.

Frequency.—A healthy male urinates five or six times in twenty-four hours (subject to individual variations). The amount passed averages about forty-five ounces, and the average capacity of the bladder may be given as ten ounces. Observation shows that a large number of diseases of the genito-urinary tract are accompanied with frequent urination. Distinction must be drawn between diseases which increase and those which do not increase urination, and those which decrease the output of urine. If the capacity of the bladder is unimpaired, the patient will urinate much oftener, as a rule, if the urinary apparatus is diseased. Among diseases which cause increased amount of urine are: diabetes mellitus and insipidus, chronic interstitial nephritis, urina spastica. In inflammatory conditions, such as prostatitis, posterior

urethritis, vesiculitis, inflammatory conditions around the verumontanum, trigonitis and cystitis, the frequency is increased, while the output of urine is normal. If the inflammation is confined to the urethra alone, such as in posterior urethritis and trigonitis, the urgency exists both day and night, while in prostatitis or hypertrophy of the prostate, frequency is usually in the nighttime. In neuroses of the bladder, frequent micturition is by day, and not by night. To contrast frequent urination of hypertrophied prostate and that of vesical calculus is quite interesting; in the former, urination is much more frequent at night. We have known patients to empty their bladder almost every hour during the night, thereby losing the much-needed rest which is so essential to prostatics, and would go with comparative ease throughout the day; while in vesical calculus quite the reverse is true—patients do well during the nighttime, oftentimes sleeping throughout the entire night without a single micturition, but, upon arising, with their accustomed daily duties, which entail exercise or movement, the frequency of urination is increased to a marked degree, as in contra-distinction to a peaceful night. You should at once appreciate the value obtained by the close questioning of your patient as to frequency and urgency of urination. This can best be done by asking if he urinates oftener than he formerly did; if he does, ascertain if the increase is night or day, or both day, and night, and if more pronounced at any special time of the day, and whether or not exercise has any influence towards increasing urinary frequency.

Changes in the Urinary Stream.—Diminution in the urinary stream is the first and constant symptom of stricture of the urethra. This is marked to such an extent (allowing for variations) that it may be said without contradiction, the tighter the stricture the smaller the stream. One can oftentimes judge a filiform stricture by the size of the stream passed. In very tight strictures the stream may be wanting altogether; the urine is then voided drop by drop. The stream is partially or entirely obliterated when the bladder loses its tonicity and force, as in tabes, or when there is some obstruction in the urethra or near the bladder neck, such as stone, enlarged prostate, and occasionally a tumor may cause

this condition. Therefore, it is our customary rule to lay particular stress on changes occurring in the urinary stream, thereby obtaining much information which oftentimes proves a nucleus tending towards the diagnosis.

Pain.—Pain, as a symptom of diseases of the genito-urinary tract, while not reliable, and subject to various interpretations, is, as a whole, exceedingly important. The first consideration of pain is its location, whether over the kidney, bladder, ureters or urethra. Its exact location should be localized, if possible, and its relation to urination specifically noted. It should be ascertained whether pain is associated with the urinary act or whether independent of urination. The relation of exercise in regard to pain, whether increased or diminished: for instance, the pain of renal colic usually occurs on the side of the diseased kidney, and radiates along the ureters to the groin, and is markedly exaggerated by movements of the patient. Pain of vesical calculus usually radiates towards the head of the penis, and is especially marked in the posterior urethra, and at times the testicles may be the seat of pain which is reflex in character. Exercise plays the most important part in increasing pain due to bladder stone.

Pain of stricture occurs, as a rule, at the strictured mass. In hypertrophy of the prostate, especially in the acute variety, the pain is felt in the perineum and rectum, and at times will radiate down the thighs. The pain of stricture of the urethra occurs during urination and intercourse, while in inflammations of the bladder-neck and trigone the pain is after urination, and persists for some time thereafter. It is useless to state that there are many exceptions to these rules, but, as in circumstantial evidence with the jurist, it is but one of many links that, when joined together by other corresponding evidence, goes to form a chain upon which the diagnosis is presumed. In the more detailed genito-urinary work diagnosis is often difficult in the extreme, occasioning the use of more intricate methods of procedure, such as cystoscopy, endoscopy and microscopic and chemical examinations of all parts of the genito-urinary tract, together with various and sundried functional tests of kidney cases, which the specialist should be prepared to enter into more minutely.

Pointers Furnished by the Macroscopic Aspect of Urine.—Normally, urine is clear, with a color of some shade of yellow, varying from nearly colorless to reddish yellow depending generally upon the degree of concentration. Its odor is characteristic; when it putrefies, the odor is ammoniacal and offensive. In cystitis, if alkaline, it is ammoniacal when passed. In suppurative diseases the odor may be putrid. Standing urine is of little diagnostic value, for the deposit is generally due to the precipitation of its salts, and its cloudiness to changes of temperature and exposure to air, with decomposition. The sediment is of value only when sedimentation occurs shortly after emission. The whitish urine is observed especially in neurasthenics, and is often associated with polyuria, especially *post prandium*. The highly-colored urine is observed in febrile conditions, also in icterus and constipated patients. In the latter, coloring is due to indican or urobilin. Exceptionally, we find in normal urine a cloudy deposit, extremely mobile, very refringent, of one to three inches' thickness. This condition is due to the presence of large quantities of mucus, which is not morbid. In the female, slightly cloudy urine may be due to the washing of the vulva during urination.

Cloudy urine, which reveals urethral, vesical or renal lesions, is rather easy of interpretation. We must, however, immediately eliminate the cloudy urine due to phosphaturia, which we may call "muddy" urine, due to its density and the general aspects which it presents. This condition is especially observed in young neurasthenic females and in young men who are anemic, fatigued, and who largely spend their time in mental or intellectual work, and is due to a large elimination of minerals. It is easy to differentiate this urine from the frankly purulent one, for, by the addition of pure glacial acetic or phosphoric acid, the salts dissolve and the limpidness of the urine reappears. This test is indispensable, often preventing the patient from receiving unnecessary medicated irrigations of the bladder. It is again important to have your patient urinate in two glasses at least, to eliminate lesions from urethra or prostate. A cloudy urine, with shreds in the first glass, the urine of the second glass being clear, will be in favor of an acute or subacute urethritis. Clear urine, with

shreds in the first, will be in favor of a chronic urethritis, with or without folliculitis.

As to the abundance and aspect of the pus in the second glass, this is what we generally meet: the urine may or may not have a deposit. In the first case it is rather difficult to state the part played by the kidney or bladder. When a deposit, however, this deposit may be grayish, slightly mobile, scarcely concrete, and not very abundant. We are then dealing with vesical pus. If the pus is due to cystitis, we have our three principal symptoms, namely: pain, purulence and frequency, with tenesmus going as far as incontinence. The cystic may be due to a simple infection brought on by catheterization. May be an infectious cystitis or a post-bleorrhagic one. May also be caused by a tight stricture. The history given by this patient will generally clear up these conditions. In tuberculosis cystitis, the family and personal history of the patient, his aspect, and the chronicity of the affection are etiologic factors of first importance, and the genital lesions, prostatovesicular or orchi-epididymary, will often, by their presence, put the seal on our diagnosis. The cystoscope will in these cases render great service.

Vesical pus may again be due to foreign bodies: stones of uric acid, phosphatic or oxalic origin; or again exogenitic bodies, as hair-pins, conductors, pieces of catheter, etc. The history of the patient, with the assistance of the cystoscope, will confirm our diagnosis.

Lastly, let us mention pus due to hypertrophied prostate, which prostatics suffer with complete or incomplete retention. This infection is due to the fermentation of the non-voided urine, and very often to the infection produced by a septic catheter. The age, history of the patient, rectal and cystoscopic examinations will clear our diagnosis. A patient may sometimes urinate large quantities of pus with no cystitis and no renal complications. We must then think of a pre-vesical abscess with secondary opening in the bladder. The cystoscope is of indispensable use in these cases (which are rare). However, the general practitioner should not overlook these cases, so as to clear the diagnosis of a difficult one.

When the deposit is greenish, abundant, dense and concrete,

falling heavily to the bottom of the glass, we are probably dealing with a hydro- or pyo-nephrosis. The infection may be tuberculous, and the whitish, soapy-water-looking urine will be in favor of this condition. In pyelitis we observe polyuria with cloudiness, urine pale, without chromogen, holding inferior qualities of urea and chlorides, well showing the feebleness of the organic exchanges.

Albuminuria, in all these cases, is present, but we must not forget that this may be simply a false or leucocytic albuminuria, not an essential one. This is the reason why the practitioner must always notice the color of the urine before making chemical examination.

Hematuria.—Hematuria, with pyuria, is one of the great syndromes which dominates the whole of urinary pathology. It is the first which attracts the attention of the patient; it invites him to consult the physician, and the primordial importance is justified by this fact: that it suffices by itself, when it is observed and analyzed, to make an almost exact diagnosis, which is not the rule with other affections, which necessitates at least the co-existence of two or more symptoms. Blood may come from the urethra or its glands, from the bladder or higher organs, the kidneys or ureters.

If the blood comes from the urethra it may be a traumatic rupture of the perineal urethra resulting from a fall, in which cases, besides the hematuria, we generally observe a perineal tumor and a reflex retention of urine. We may also observe a bloody discharge in urethral polypi and urethral calculi diagnosed with the urethroscope. In these cases, which we may call "distilling urethrorrhagia," the blood escapes drop by drop from the meatus. We are not then dealing with a true hematuria, as will be mentioned in the following affections:

If the blood comes from the urethral glands, prostate or seminal vesicles, we are now dealing with an initial hematuria, one of "washing." The first jet of urine chases the secretion which may have collected in the prostatic urethra, and we have then a slight hematuria, slightly cloudy, rusty-colored as a rule, with clots of a brown haze, and we must then think of a beginning cancerous

prostate. In more advanced cases the diagnosis will depend on the rectal touch and the state of the prostate, which is of a linear hardness, filled with nodules, varying from the size of a pea to that of a large nut. Truly, it is rare that we observe hematuria in true hypertrophy of the prostate, tuberculous prostatitis or diffuse prostatic-pelvic carcinomata. Allow us to state, rapidly, the bloody ejaculations (hemasprenia) which we rarely observe in certain non-specific vesiculitis.

If the Blood Comes from the Bladder—With Cystitis.—If the blood is present during the whole of micturition, or only at the end (total or terminal hematuria, we are dealing with a hemorrhage of the body of the bladder with co-existing symptoms, pain, pyuria and frequency; or, again, with a hemorrhage from the neck of the bladder, its most vascular region. In intense cases the bloody appearance from the middle portion of the micturition will be more pronounced than at the end, which already allows us to differentiate it from renal hematuria. In cases of simple inflammatory hematuria of gonorrheal origin the patient's history will make the diagnosis. Very often, also, we are dealing with a tuberculous hematuria, with or without ulcerations. Our diagnosis is based on the general condition of the patient, which is usually precarious, on the small bladder capacity, the existence of other lesions of the uro-genital apparatus, and in particular on the frequent presence of a nodule, round and hard, at the junction of the prostate and one of the seminal vesicles, and lastly the finding of the Koch bacillus and the disintegration of the white blood cells and the inoculation of the guinea-pig.

We must also mention hematuria due to foreign bodies, and in particular hematuria due to calculi. We recognize the condition rather easily, for its character is that of being "provoqued"—that is, that it appears preferably during the evening after a hard day's work, a prolonged walk, a ride in a carriage, car or other vehicle. With this pathognomonic sign we may have pain radiating towards the end of the penis, pyuria, frequency of micturition, and occasional stopping of the urinary stream due to the stone acting as a ball valve.

Without Cystitis.—When blood comes from the bladder without cystitis we must immediately think of vesical tumor. The hematuria is generally *spontaneous*, coming on at any time during the day or night, and which distinguishes it from the “provoqued” hematuria caused by calculi. This hematuria may be very abundant, red or black, and most frequently with clots. We do not dwell too deeply on the hematuria due to hypertrophy of the prostate, which is one of congestion, easily diagnosticated. Also, hematuria due to too rapid evacuation of a largely distended bladder.

The blood comes from the reno-ureteral apparatus. The general characters of renal hematuria may be classed thus: First, it is, as a rule, except perhaps in T. B., rather marked; second, the hematuria is generally total—that is, the urine is equally colored from beginning to end in micturition; third, the hematuria contains long clots, rounded and moulded in the ureter.

In this hematuria, of renal origin, we recognize numerous causes which we may divide into hematuria of rare causes and hematuria of frequent causes. In hemorrhages due to rare causes we may mention acute nephritis due to scarlatina, pneumonia, diphtheria, etc., the diagnosis of which presents little difficulty. Also chronic nephritis (Bright), with albuminuria and casts associated with the hematuria. We might mention hematuria due to renal congestion during pregnancy, and also that due to floating kidney, observed so frequently on the right side of women.

Of the frequent causes of renal hematuria, the three most important are; tuberculosis, calculi, and cancer. Renal hematuria due to tuberculosis is mostly unilateral in the beginning, may present only slight hemorrhage, giving just a pink tint to the urine. The patients are generally children or young adults, rarely old persons, and the hemorrhage may be rather discrete for a while. Palpation is difficult, especially during the period of granulation or ulceration. Our diagnosis is based on the fact that, outside of these periodical hematuriae, the urine remains cloudy—that is, pyuria co-exists. Hematuria of renal tuberculosis is not accompanied by pain, as a rule, is seldom influenced by fatigue or rest, but appears at any time.

Renal calculi causing hemorrhage is often associated with pain in the lumbar region, radiating down the groin into the testicle, with pyuria, and its main feature is that it is "provoqued." Usually the kidney is not palpable. Hematuria due to renal cancer is almost always spontaneous, and generally one of the late symptoms of renal cancer, and when the patient presents this condition we may be sure to find an enlarged kidney. Outside of the periods of hematuria the urine remains clear.

And, in conclusion, we will state that hematuria not associated with organic trouble may be caused by medicinal substances—mercury, cantharides, etc.—which often disappear when the drug is discontinued. Parasitic hematuria, filaria sanguinis, is only observed in patients coming from warm climates, and who, besides hematuria, suffer with chyluria.—*New Orleans Medical and Surgical Journal*.

Extracts from Home and Foreign Journals.

SURGICAL

THE RADICAL CURE OF HERNIA IN INFANTS AND YOUNG CHILDREN.

Kellock (Proceedings of Royal Society of Medicine) says that considerable importance should be given the origin of inguinal hernia in young children, so far as the sac, at any rate, is concerned, and thinks that the only "acquired" factor is the protrusion of some viscus into an already existing sac. The writer holds that operation can and should be done at any early age, and believes that a suitable procedure is one he has reduced to a very simple form. Some importance is attached to preparatory treatment. An infant who has a hernia of any size is kept for a few days before the operation in the Trendelenburg position, with the feet and legs over a wedge pillow, so that the hernia is kept out of the way. In the operation itself, an inch incision is made through the skin at right angles to the direction of the cord, and just above the external abdominal ring. This incision is well away from the genitals, and is accompanied by very little bleeding. The coverings of the cord being divided longitudinally, the sac is found, isolated, drawn down, transfixed and ligatured as high up as it can be reached, and the skin wound then closed.—*Charlotte Medical Journal*.

ROBBING SURGERY OF ITS TERRORS.

As Dr. Crile explains it: "Anæsthesia puts asleep only a portion of brain, and is at best only a veneer. Rough manipulation of the viscera excites an involuntary reactive opposition of the

patient to the surgeon, a silent protest of the unconscious patient against physical injury."

Now Crile conceived the idea that if he could temporarily cut off communication between the field of operation and the brain—prevent the nerves from carrying "insults" to headquarters—the occurrence of shock might be prevented. He performed hundreds of experiments on animals under ether with the operation field cocainized in addition, and found that the cocaine prevented the transmission of these injurious impulses, and so prevented shock.

The principal was then applied to the human subject with happy results. An extremely dilute solution of cocaine or similar drug is used, not enough to involve any danger from the drug; it benumbs the nerve endings in the wound, being purposely injected in and about the nerve-trunks that supply the part to be operated on, after the patient is well under ether. This effectually "blocks off" the part, prevents the transmission of alarms to the brain, and thus completely cuts off control from headquarters for the time being.—*William Brady, M.D., in Harper's Weekly.*

OBSTETRICAL

THE ETHICS OF ABORTION.

The ethical aspects of abortion always challenge a thoughtful mind. Many have grave doubts as to the advisability of refusing to perform abortion on young girls who were actually seduced under promise of marriage; or on raped imbeciles or on those married women suffering from tuberculosis, Bright's disease, pathologic vomiting, or incipient melancholia; or on poor married women who must needs support by the sweat of their brows, their many undesired children resulting from the marital right; or on those daring women who feel that breeding is not their sole function in life.

The problem has but one answer to some fortunate few. The

many, however, will not be convinced by the dogmatic solution presented by Edward Nammack, M.D., in the Medical Record for September 14, 1912. For the benefit of those medical thinkers and sociological workers who have been discussing and considering this problem, we print the paragraph that indicates what a trifling ethical question abortion offered the believer.

"The ethical aspects of abortion need not detain us long. There is no ethical question to be solved by the man who believes that there is a God, and that this God gave to Moses on Mount Sinai, the commandment 'Thou shalt not kill.' To the man who does not so believe, argument is a waste of time."

The same commandment possibly might be construed as referring to war or even to the payment of starvation wages. The ethical aspects of abortion might have detained us longer.—*Medical Review of Reviews*.

A MODIFICATION OF THE STEM OPERATION FOR STERILITY AND DYSMENORRHEA.

Dr. L. Grant Baldwin described a new operative technic for application in cases of sterility. The stem pessary is used, and in order to hold it in place two small buttons are placed on either side of the cervix and the thread is passed through the hole in one button, then through the second hole in the same button, then through one side of the cervix, through the stem, through the button on the opposite side, then through the other side of the cervix and back to the original point and tied. This procedure is done in order to prevent the sutures from cutting out of the cervix. It is best to thread the buttons through the stem before introducing it, then all that has to be done inside of the vagina is to tie the knot over the second button.

As a preliminary to the use of the stem pessary, Dr. Baldwin discussed curetting and draining the uterus before inserting. In order to drain the uterus he mops it out with gauze and usually puts in a good sized glass catheter. It is found that a solid glass rod drains better than the hollow glass tube.—*Long Island Medical Journal*.

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at \$1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

CLOSE OF VOLUME CVI.

Sixty-two years ago the *Nashville Journal of Medicine and Surgery* was launched upon the tempestuous seas of medical journalism by its distinguished founder, Dr. W. K. Bowling, since which time it has lived a checkered existence of varying fortunes. Whatever may be considered the result of this journalistic venture, whatever influences it may have exerted, whatever assistance it may have afforded its readers, whatever its present standing, one thing may be said to its credit, the *Journal* still lives. This too, at a time when circumstances surrounding the being of an independent medical journal have changed to such an extent as to make its life precarious. Looking back over its history since its beginning, over half a century ago, we recall that its destinies were directed by such editors as W. K. Bowling, Paul F. Eve, Sr., W. T. Briggs, W. L. Nichol, Thomas O. Summers, each one of whom at different times occupied the editorial tripod and administered its control. It can not be controverted that the *Nashville Journal of Medicine and Surgery* has in the past under such management been an element of importance, journalistically speaking, with the medical profession of the South. Under the present management it is still striving to win the esteem and support of medical men. It is still endeavoring to maintain the same high standard of excellence established by its founder. To accomplish this the editor bespeaks the encouragement and aid of the physicians of the South. The object and aims of the *Journal*

are the same as those declared by its founders, namely, a periodical that may serve as a medium for the publication of scientific papers, for the selection of papers of worth and note, the abstraction from other journals of practical notes that will help its readers in their work, editorial discussions of questions of the day, and reviews of present day publications as they issue from the press. The present editor has been at the helm for nearly forty years, and in all that time he has conscientiously tried to editorially live up to the high standard of his predecessors, and to conduct a journal that would be of some aid to his contemporaries. If in no other way, he has at least succeeded in this—in carrying on his journalistic enterprise for a longer time than probably any other American medical editor. With the aid of our friends we shall continue the work. We ask their coöperation. The profession of the South should have some sort of pride in a Southern product that has weathered the storm so long, and should support it, unmindful of efforts of the present day to smother out the life of all enterprises not founded on graft, and by such effort keep alive a journal that has for so long a time been a steadfast exponent of scientific progressive medicine. Bespeaking therefore the support and aid of physicians of the South, and thanking our friends for their kindness and help in the past, we extend to every member of the profession our heartfelt wishes for a merry Christmas and a Happy New Year.

TO SUBSCRIBERS.

Statements have been sent to subscribers for subscriptions due to the Journal, and we have asked a settlement and renewal with the beginning of the New Year. Many have responded by sending in their dues and renewals for another year. Quite a number remain from whom there have been no responses. A few claim to have ordered the Journal discontinued. We ask all who have not replied to do so at once, as it is important in making up a mailing list for the year to have it correct. We do not want names on the list that will claim to have had their subscription stopped. We have to have, as required by law, a paid up sub-

scription, and therefore have called editorial attention to it in this way. We beg our readers to let us hear from them without delay. Begin the year with good deeds and the year will bring success. One thing we do ask, and that is let us know at once whether you wish your subscription continued or stopped.

NEW POSTAL LAW.

Statement of the ownership, management, circulation, etc., of the Nashville Journal of Medicine and Surgery, published monthly, at Nashville, Tenn., required by the act of August 24, 1912.

Note.—This statement is to be in duplicate, both copies to be delivered by the publisher to the postmaster, who will send one copy to the Third Assistant Postmaster General (Division of Classification), Washington, D. C., and retain the other in the files of the postoffice.

Name of Editor,
C. S. Briggs, A.M., M.D.

Postoffice address,
302½ 5th Av., N.
Nashville, Tenn

Managing Editor, C. S. Briggs, M.D.

Business Manager, C. S. Briggs, M.D.

Publisher, C. S. Briggs, M.D.

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Owners: (If a corporation, give names and addresses of stockholders holding 1 per cent or more of total amount of stock.)

C. S. Briggs, M.D., 302½ Fifth Avenue, North, Nashville, Tenn.

Known bondholders, mortgagees and other security holders, holding 1 per cent or more of total amount of bonds, mortgages or other securities.

None.

(If additional space is needed, a sheet of paper may be attached to this form.)

Average number of copies of each issue of the publication sold or distributed, through the mails or otherwise, to paid subscribers during the six months preceding the date of this statement.

(This information is required from daily papers only.)

C. S. BRIGGS, M.D.

(Signature of editor, publisher, business manager and owner.)

Sworn to and subscribed before me this 18th day of December, 1912.

T. W. HALES,

Notary Public in and for the city and county of Davidson, State of Tennessee.

(My commission expires January, 1916.

(Seal.)

A WOMAN PHYSICIAN IS NEEDED.

This is a Christian hospital, opened in 1900, two years after a dispensary had been started.

In one year more than 10,000 treatments have been given, 530 in-patients cared for, in addition to many visited in the city and district.

Jhansi, a city whose population is 55,724, is situated in nearly the geographical center of India. It is a large military cantonment and civil station, and the headquarters of the Indian Midland Railway Administration. Throughout a vast region for hundreds of miles villages are thickly scattered, in very few of which the gospel has ever been preached. The city and region are full of Mohammedans in addition to the Hindus. There are not more than fifteen foreign Christian missionary workers in the community.

All in-patients are under regular Christian instruction, and many who are now Christians state that they were first led to think of God as Father and Christ as Saviour by reading portions of Scripture given to them in the hospital or dispensary.

Patients come not only from the city, but from the neighboring native states, and from distant towns and villages. One recently came from the State of Datia, where no mission work has ever been done. Besides having a successful operation performed she was taught to read in Hindi, and upon returning home took many tracts and portions of Scripture, which she promised to distribute carefully.

Successful cases bring many friends. Among the patients was a son of a washerwoman, who had all the superstitions and prejudices of his caste. The hospital staff were not told of the child's

illness until he had become worse under the treatment of native doctors, and was approaching the crisis of pneumonia. He was finally brought to the hospital. In addition to his weakness, he screamed constantly from an abscess in the middle ear, brought on doubtlessly by lack of proper treatment in the earlier stages. *His relatives were sure that he was possessed with a devil, and insisted upon taking him home and summoning the devil doctor. Their treatment consists in beating and torturing the patient, under the mistaken idea that they are afflicting the devil, who will leave the patient and find a more peaceable abode.* Meantime, not only the relatives, but many people of his caste, arrived at the hospital and began a loud wail of lamentation. After strenuous efforts the parents were persuaded to leave the child at the hospital, with the result that he has completely recovered. Cases like this do much in breaking down false belief and worship.

This post requires a woman of thorough medical training, unimpaired physical constitution, good sense, sound judgment, capacity for leadership, a cheerful, hopeful spirit, ability to work pleasantly with others—all controlled by a single-hearted, self-sacrificing devotion to Christ and His cause. She should be prepared to make her professional knowledge and skill directly subservient to the furtherance of the Gospel.

Support is provided by the Woman's Union Missionary Society, and includes traveling expenses, living quarters, and outfit allowance, in addition to the regular missionary salary, which is based upon what experience to be necessary to maintain the worker comfortably.

For further particulars write to Mr. Wilbert B. Smith, Candidate Secretary, Student Volunteer Movement, 125 East 27th St., New York City.

ANOTHER CHRISTIAN DOCTOR NEEDED.

This is a missionary hospital, which was started by the Methodist Episcopal Church. Another Christian doctor is needed for the staff.

Guanajuato is a city of 60,000, the capital of the state of the same name. It is located 160 miles northwest of Mexico City. It stands at an altitude of 6,500 feet in a rich silver-mining region. The Mexican Central Railroad passes through the city.

One year's report of the hospital staff shows 339 visits to homes, 4,579 consultations, 24,523 treatments, 52 major and 279 minor surgical operations, medicines furnished 17,587 patients. Fifteen different nationalities were included among those who were treated.

For this internship a man is required who has had a thorough medical education and who is prepared to make his professional knowledge and skill directly subservient to the furtherance of the Gospel.

Communications may be addressed to the director of the hospital, Dr. Levi B. Salmans, Good Samaritan Hospital, Guanajuato, Mexico.

The undersigned will be glad to communicate with any medical men who are interested in the need for physicians in foreign countries.

Mrs. Wilbert B. Smith, 125 27th Street, New York City.

DENTAL INTERNE (MALE).

December 11, 1912.

The United States Civil Service Commission announces an open examination for dental interne, for men only, on December 11, 1912, at the places mentioned in the list printed hereon. From the register of eligibles resulting from this examination certification will be made to fill a vacancy in the position of dental interne at \$600 per annum, with maintenance, in the Government Hospital for the Insane, Washington, D. C., and vacancies as they may occur requiring similar qualifications, unless it is found to be in the interest of the service to fill any vacancy by reinstatement, transfer, or promotion.

The Department states that it reserves the right to terminate the appointment at the expiration of one year of service if it is deemed advisable to do so.

As no applications were filed for the examination for this position announced to be held on October 23, 1912, qualified persons are urged to enter this examination.

In addition to the many interesting cases presented, the dental interne is given an excellent opportunity for study and for doing experimental and research work in the pathological, histological, and other laboratories of the institution.

Competitors will be examined in the following subject, which will have the relative weights indicated.

<i>Subjects</i>	<i>Weights</i>
1. Letter writing (the subject matter on a topic relative to the practice of dentistry)-----	5
2. Anatomy and physiology (general questions on these branches, also with reference to the teeth, mouth, and head)-----	10
3. Chemistry, materia medica, and therapeutics (the preparation, properties, and reactions of chemicals, crude drugs and their preparations, their action and application, with those of other therapeutic agencies)-----	15
4. Dental pathology and oral surgery (the morbid process incident to diseases and injuries of the teeth, mouth, and contingent structures, and their surgical treatment)-----	20
5. Operative and prosthetic dentistry (the detailed technics of general and special operative and laboratory work)-----	25
6. Bacteriology, histology, and hygiene (the cultivation, isolation, demonstration of bacteria, the principles of sterilization, mounting specimens, use of microscope, the principles of general and oral hygiene, etc.)---	10
7. Orthodontia (local and constitutional irregularities in growth and development of the teeth, and their correction)-----	15
Total-----	100

Applicants are required to be graduates of regularly incorporated dental colleges, and applications will not be accepted from persons who have been graduates more than two years.

Statements as to training, experience, and fitness are accepted subject to verification.

Applicants must be unmarried.

Age, 20 years or over on the date of the examination.

This examination is open to all male citizens of the United States who meet the requirements.

Persons who meet the requirements and desire this examination should at once apply either to the United States Civil Service Commission, Washington, D. C., or to the secretary of the board of examiners at any place mentioned in the list printed hereon, for application and examination Form 1312. No application will be accepted unless properly executed and filed with the Commission at Washington. In applying for this examination the exact title as given at the head of this announcement should be used.

As examination papers are shipped direct from the Commission to the places of examination, it is necessary that applications be received in ample time to arrange for the examination desired at the place indicated by the applicant. The Commission will therefore arrange to examine any applicant whose application is received in time to permit the shipment of the necessary papers.

Issued November 11, 1912.

DR. L. B. GRADDY.

The memory of Dr. L. B. Graddy, a prominent physician who formerly lived in Nashville, who died recently, has been honored by the Nashville Academy of Medicine and the Davidson County Medical Society. Suitable resolutions on his death have been adopted. The resolutions in full follow:

WHEREAS, The death of Dr. L. B. Graddy has taken from our city a valuable citizen and from the local profession a distinguished and esteemed member, and

WHEREAS, We fully appreciate the qualities of mind and heart that made Dr. Graddy a figure of national as well as local professional importance, and endeared him to a legion of personal friends; be it

Resolved, That the Nashville Academy of Medicine and Davidson County Medical Society does hereby express its keen sense of the great loss it and the profession generally has sustained. Be it further

Resolved, That in order to give public expression to our regard for our departed colleague, and to our feeling of serious misfortune through his death, that the local papers be requested to publish these resolutions. Be it further

Resolved, That our secretary be directed to forward a copy of the resolutions to Dr. Graddy's family and to assure them that the medical profession and the community at large have, with them, suffered an irretrievable loss.

RICHARD A. BARR,
W. FRANK GLENN,
M. C. MCGANNON,
W. M. McCABE,
E. B. CAYCE.

BIRTH.

To Dr. William Thompson and Artemisia Howard Briggs, December 3, 1912, a girl.

Reviews and Book Notices

Progressive Medicine.—A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Diagnosis in the Jefferson Medical College of Philadelphia, Physician to the Jefferson Medical College; One Time Clinical Professor of Diseases of Children in the University of Pennsylvania; Member of the Association of American Physicians, Etc. Assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia; Ophthalmologist to the Frederick Douglass Memorial Hospital; Instructor in Ophthalmology, Philadelphia Polyclinic Hospital and College for Graduates in Medicine. Volume IV. December, 1912. Diseases of the Digestive Tract and Allied Organs, the Liver, Pancreas and Peritoneum—Diseases of the Kidneys—Genito-Urinary Diseases—Surgery of the Extremities, Shock, Anaesthesia, Infections, Fractures and Dislocations, and Tumors—Practical Therapeutic Referendum. Lea & Febiger, Philadelphia and New York. 1912.

We acknowledge with thanks to the publishers the receipt of this quarterly, which we have always regarded as the most valuable serial publication before the profession. The name *Progressive Medicine* is peculiarly appropriate, as it presents the advances, discoveries and improvement in medicine and surgery as they are being made from day to day. The work of the editors is all that it should be, and that of the contributors most excellent. The contributors to each number have been selected as being authorities upon the subjects assigned to them, and each department is exhaustive, in that nothing of progress has escaped them. The contents and authors are as follows: "Diseases of the Digestive Tract and Allied Organs; The Liver, Pancreas and Peritoneum, by Edward H. Goodman, M.D., Philadelphia; Diseases of The Kidneys, by John Rose Bradford, M.D., F. R. C. P., F. R. S., London; Genito-Urinary Diseases, by Charles W. Brown, M. D., Surgery of the Extremities, Shock, Anæsthesia, Infections, Fractures and Dislocations and Tumors, by Joseph C. Bloodgood M. D.; Practical Therapeutic Referendum, by H. R. M. Landis, M. D., Philadelphia; Index. We say of this serial as we have said of preceding volumes, that the practical physician can not make a

better investment than the six dollars per annum subscription price of this quarterly.

The Practitioner's Visiting List for 1913.—An invaluable pocket-sized book, containing memoranda and data important for every physician, and ruled blanks for recording every detail of practice. The Weekly, Monthly and 30-Patient Perpetual contain 32 pages of data and 160 pages of classified blanks. The 60-Patient Perpetual consists of 256 pages of blanks alone. Each in one wallet-shaped book, bound in flexible leather, with flap and pocket, pencil with rubber, and calendar for two years. Price by mail, postpaid, to any address, \$1.25. Thumb-letter index, 25 cents extra. Descriptive circular, showing the several styles, sent on request. Lea & Febiger, Publishers, Philadelphia and New York.

We take pleasure in calling the attention of our readers to the Practitioner's Visiting List, which appears in the twenty-ninth year of issue with this copy. Certainly no better visiting list is prepared for physicians than this. It is compact, well arranged, and systematized. The text in this issue is brought fully up to date, and contains a scheme of dentition, tables of weights and measures, instructions for examining the urine, diagnostic tables of eruptive disease, incompatibles, poisons and antidotes, artificial respiration, table of doses, alphabetical table of diseases and their remedies and directions for ligation of arteries—almost a cyclopedia of important information in a nutshell. This Visiting List is elegantly gotten up, and is well calculated to stand the hard usage given it in its use during the year.

A System of Surgery.—Edited by C. C. Choyce, B.Sc., M.D., F. R. C. S., Dean of and Teacher of Operative Surgery in the London School of Clinical Medicine (Postgraduate); Assistant Surgeon to the Seaman's Hospital, Greenwich; Surgeon to Out-Patients at the Great Northern Hospital. Pathological Editor, I. Martin Beattie, M.A., M.D., C.M., Professor of Pathology and Bacteriology, and Dean of the Faculty of Medicine in the University of Sheffield Royal Infirmary and Royal Hospital. In Three Volumes. Vol. I., with 16 Colored Plates, 64 Black and White Plates and 250 Illustrations in the Text. New York. Fink & Wagnalls Co. 1912.

Our thanks are due the obliging publishers for Volumes I and II of this new work on Surgery. The concluding volume will be

issued in a short time. The work is a composite one, and is made up by the contributions of a selected corps of authors, each contribution being in the form of an elaborate monograph on the subject treated. The authors are for the most part well known English surgeons, whose views upon the themes assigned them are authoritative. The entire field of surgery has been covered, and the work has been so ably edited that scarcely a break is to be observed between the articles. Volume I is devoted chiefly to surgical pathology and general surgery, whilst Vol. II and II are made up of a systematic description of the surgical diseases of the various organs and regions. The limited space preclude a full description of surgical operations, the lines of operation procedures being merely indicated. Diseases of the eye and ear and cutaneous diseases have been omitted. We feel sure that in this work surgeons will find a most useful help to keep himself abreast of the most modern teachings of surgeons, and students will find in it a most valuable aid in his advanced studies. The publishers are to be congratulated upon the excellent manner in which they have gotten up the work. We can conscientiously recommend the work to the profession.

E. Merck's Annual Report of Recent Advances in Pharmaceutical Chemistry and Therapeutics. 1911. Vol. XXV. E. Merck Chemical Works, Darmstadt, 1912.

We acknowledge with thanks the receipt of this valuable report that will serve as a very useful handbook for physicians in their daily work. It supplies a real want. For quick reference as to properties and uses of the various drugs this report furnishes a valuable help to physicians. This volume, XXV, is fully revised and brought completely up with the times. We have only one objection to urge to the copy sent us, and that is that it has not a more substantial cover, as a work that is so frequently consulted should be proof against wearing out too soon.

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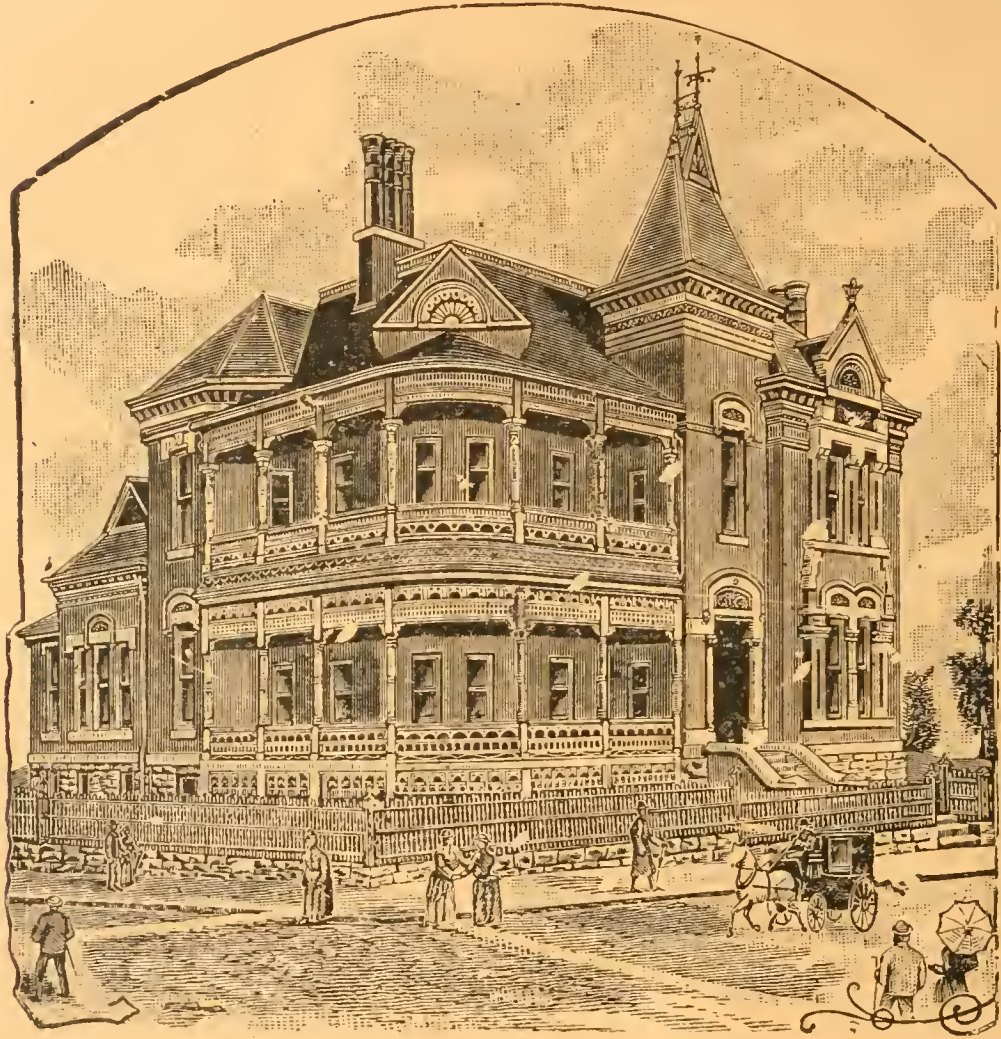
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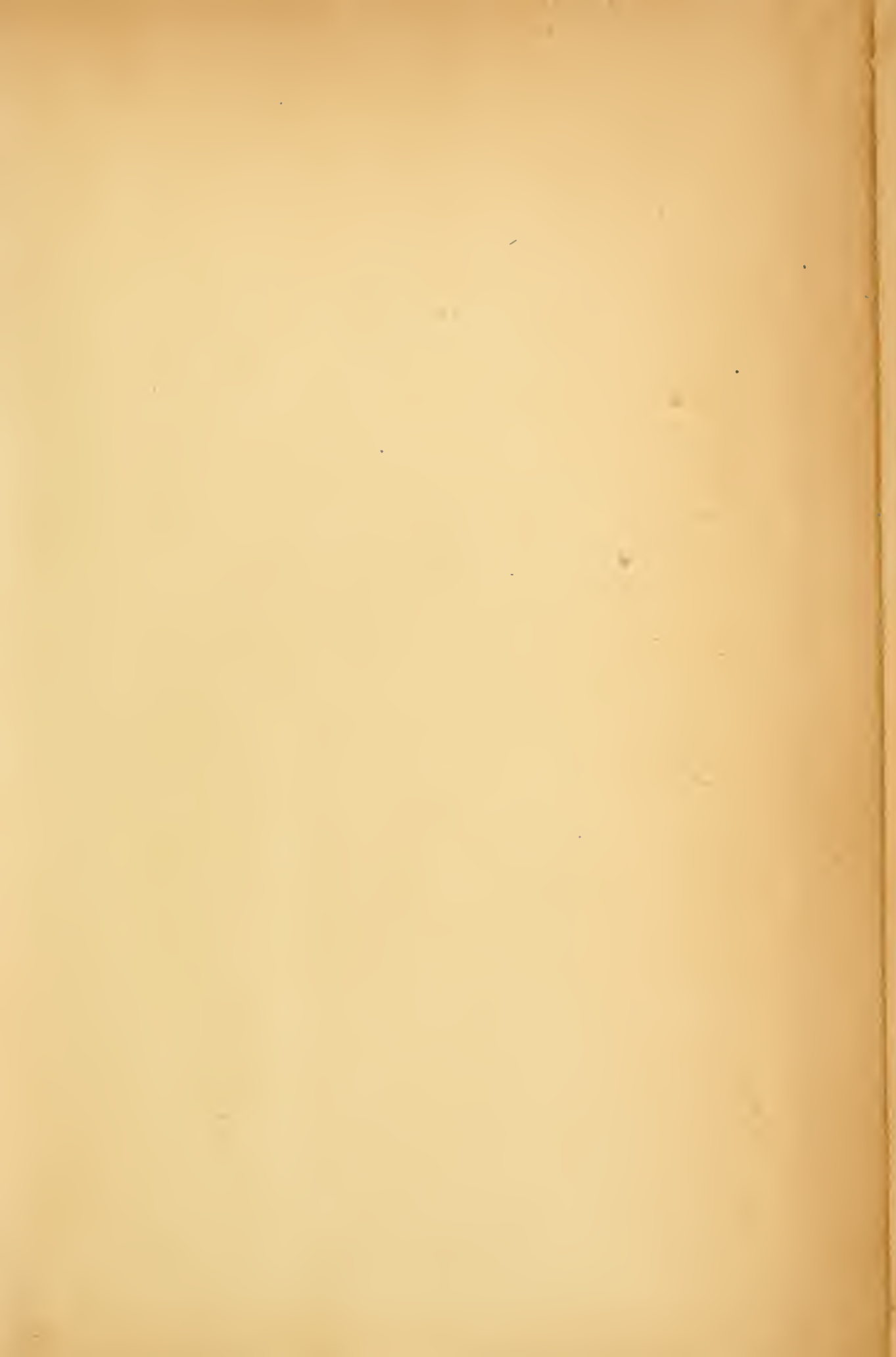
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